CITY OF RACINE
FAMILY AND MEDICAL LEAVE OF ABSENCE REQUEST FORM

Name: _____ **Emp. ID#:** _____

Home Address: _____

City: _____ **State:** _____**Zip:** _____ **Phone Number:** (_____) _____

Department: _____ **Position:** _____

*I request a leave as provided by the Family and Medical Leave Act for the following period (**required**):*

Anticipated Leave Start Date: _____ **Anticipated End Date:** _____ **Intermittent?:** _____**Yes** _____**No**

The leave is requested for the following reason:

_____ The birth of a child or placement of a child for adoption or foster care
_____ My own serious health condition
_____ To care for my spouse ____, child _____, parent _____ parent-in-law (under WI FMLA) _____ due to his/her serious health condition (check)
_____ Qualifying exigency due to my spouse _____, child _____, parent _____ being on covered active duty or called to covered active duty status with the Armed Forces (check one).
_____ Because I am the _____spouse; _____ son/daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness (check one).

I request to substitute the following days:

_____ FMLA Casual Time	_____ days	(TMS Code 70)
_____ FMLA Unpaid leave	_____ days	(TMS Code 71)
_____ FMLA Sick Time	_____ days	(TMS Code 72)
_____ FMLA Vacation Time	_____ days	(TMS Code 73)
_____ FMLA Comp Time	_____ days	(TMS Code 74)
_____ FMLA Holiday (Police/Fire only)	_____ days	(TMS Code 75)
_____ FMLA WC Accident Paid	_____ days	(TMS Code 76)
_____ FMLA WC No Pay	_____ days	(TMS Code 77)
_____ FMLA Floating Holiday	_____ day	(TMS Code 78)

(**Note:** *The substitution of the aforementioned days for family or medical leave will not extend or result in any additional leave. Under Federal law, the City may require substitution of paid time during the length of the leave).*

RETURN TO WORK CERTIFICATION: I understand that if I am requesting medical leave for my serious health condition, I must not only provide the City of Racine with a certification from my health care provider as to the existence of my serious health condition, but must also provide the City of Racine with a Return to Work Certification which has been completed by my physician. I understand that failure to provide the Return to Work Certification may result in my being denied reinstatement until such document is provided to the Human Resources Department. In the event that I desire to return to work prior to the expiration of my leave, I will notify the City at least two (2) business days prior to my desired return date.

ALTERNATIVE POSITION DURING LEAVE: I understand and agree that if my leave is requested to be taken on a reduced or intermittent basis and I am capable of performing work during my requested leave, the City may place me in alternative employment within the City and I hereby agree to such placement. I understand that the position that I may be placed in is only temporary. I will be returned to my position or substantially equivalent employment upon expiration of my leave (providing I am physically capable of performing the functions of the position).

If you are requesting intermittent or reduced leave, please provide a schedule of the leave. The Human Resources Department will notify you if it agrees with your intermittent or reduced leave proposed schedule.

Employee Signature: _____ **Date:** _____

Supervisor Acknowledgement: _____ **Date:** _____

Date Received: _____ **Human Resources Signature:** _____