BAYFIELD COUNTY
FAMILY & MEDICAL LEAVE REQUEST

EMPLOYEE: PLEASE COMPLETE THE TOP SECTION OF THIS FORM AND RETURN TO THE COUNTY ADMINISTRATOR

Employee: Phone:

Home Mailing Address:

Department: Title:

REASON FOR REQUEST (Check one)		
☐ Serious Health Condition of Employee		
☐ Placement for Adoption/Foster Care	Date to Begin Care of Child:	
☐ Birth of a Child	Expected Due Date:	
☐ Leave to Care for a Family Member	Name:	Relationship:
☐ Military Family (Exigency) Leave	Name:	Relationship:
☐ Military Care Giver Leave	Name:	Relationship:
☐ Other		
☐ Emergency Expansion-To care for a child under 18 of an employee if the child's school or place of care has been closed, or the childcare provider is unavailable, due to a public health emergency (Medical Certification Form is not required)		

Requested Start Date: Anticipated Return to Work Date:

Intermittent or reduced work schedule (describe):

A leave of absence may consist of leave without pay and/or paid leave (vacation, sick leave, compensatory time off). Paid leave may be used in accordance with applicable policy/contracts. Paid leave must be exhausted before unpaid leave will be granted.

Employee signature & date: _____

DESIGNATION OF LEAVE

COUNTY ADMINISTRATOR: PLEASE COMPLETE THE BOTTOM SECTION OF THIS FORM

☐ Your leave is provisionally approved – pending medical verification.
☐ Your leave is approved.
☐ Your leave is denied for the following reason(s):

From	**Through**	**Qualifies as Family & Medical Leave**

Confirmation of status during leave:

Type	**Hours**	**From**	**Through**
Vacation			
Sick Leave			
Comp Time Off			
Floating Holiday			
Emergency Leave Bank			
Worker's Comp			
Leave w/o Pay			

Supervisor Signature & Date: _____

Notice to Employee
FAMILY & MEDICAL LEAVE: YOUR RIGHTS AND OBLIGATIONS

Bayfield County provides family and medical leave (FML) to eligible employees in accordance with the state and federal Family and Medical Leave Acts. This notice summarizes your rights and obligations under these laws. For more detailed information, please read the "Leave of Absence" section of the union contract or personnel policy that applies to you.

Eligibility for Leave

The federal **Family & Medical Leave Act** (FMLA) entitles employees to up to 12 weeks of leave for their own serious health condition; the birth of a child; care of a newborn, newly adopted child or new foster care placement; or the care of a spouse, child or parent with a serious health condition. (For complete information, see the personnel policies and procedures manual.)

Federal FML Eligibility Requirements

- The employee must have at least 12 months of County service. All prior service counts, regardless of any service breaks.
- The employee must have worked at least 1250 hours during the 12 months immediately preceding the commencement of the leave.
- The employee must not have utilized their 12 weeks within the current rolling year.

State FML Eligibility Requirements

- The employee must have at least 52 consecutive weeks of County service.
- The employee must have worked or received paid benefit time totaling at least 1000 hours during the 52 weeks immediately preceding the commencement of the leave.

Purpose of Leave

You may use FML for your own serious health condition, for the serious health condition of your spouse, child, or parent, or to care for your child after birth or placement by adoption or foster care.

Length of Leave

Your leave will be counted against your entitlement of up to 12 workweeks per year under federal FML. The County uses the "rolling year" method of calculating the 12 workweeks. You may take your leave in several blocks of time, on an intermittent basis or as a reduced work schedule, if medically necessary.

Leaves under the ***Federal*** FML run concurrent with paid leave time and worker's compensation. ***State*** FML will only be designated upon request by the employee.

Pay

FML is normally unpaid leave; however, you are required to substitute paid leave (i.e., accrued vacation or sick leave) for all or a portion of the unpaid leave, as described in the personnel policy or union contract that applies to you.

Advance Notice

30 days advance notice is required if your need for leave is foreseeable. For events which are unforeseeable, you must notify the County as soon as possible. Failure to comply with these notice rules may result in deferral or denial of the requested leave.

Medical Certification

Written certification from a health care provider is required for either your own serious health condition or the serious health condition of your family member. Failure to provide certification within 15 calendar days of the date you receive this notice may result in delay or denial of leave until the certification is provided.

Recertification of the serious health condition may be required under certain circumstances, as described in federal and state law.

A "health care provider" is defined as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, or nurse-midwife who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner.

Health Benefits

Coverage under your group medical plan will continue during FML for up to 12 workweeks. You are responsible for contacting the County Clerk's Office to pay the employee portion of any premiums that are not covered by the County's contribution. Failure to pay your portion of the premiums within 30 days of the due date will result in cancellation of your coverage.

Reinstatement

Under the law, you must be reinstated to the same position you had prior to taking the leave, or to an equivalent position if you return to work immediately after FML. However, you have no greater right to reinstatement than you would have had if you had been continuously at work. See the provisions of your personnel policy or union contract for more information.

If the leave was for your own serious health condition you must present medical certification of your ability to return to work.

Confidentiality

Bayfield County shall follow HIPAA privacy practices with regard to Protected Health Information.

BAYFIELD COUNTY
FAMILY AND MEDICAL LEAVE CERTIFICATION

EMPLOYEE: PLEASE FILL OUT THIS SECTION, AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER.

Employee:	
Patient (if other than employee):	Relation to employee:
Begin and end dates of requested leave: _____ to _____	

HEALTH CARE PROVIDER: PLEASE FILL OUT THIS SECTION AND RETURN AS SHOWN BELOW.

Does the patient have a serious health condition ☐ Yes ☐ No (If yes, please check reason):

☐ 1. Hospital Stay
☐ 2. Incapacity plus Treatment -- condition that causes 3 days of incapacity and
  ☐ two or more treatments by a health care provider; or
  ☐ one treatment plus a continuing regimen under supervision of a health care provider
  Please request employee's job description if needed to determine "incapacity."
☐ 3. Pregnancy -- any period of incapacity due to pregnancy or prenatal care.
☐ 4. Chronic Serious Health Condition
☐ 5. Permanent or Long-Term Conditions -- requiring medical supervision
☐ 6. Multiple Treatments for Non-Chronic Condition

If the leave is to care for a family member, is the employee's presence necessary or would it be beneficial to the patient? ☐ Yes ☐ No

When did the serious health condition begin?

When is the anticipated return to work date?

Is intermittent leave or a reduced work schedule medically necessary? ☐ Yes ☐ No (If yes, describe):

Name of Health Care Provider:

Specialty:

Signature of Health Care Provider	Date	Address

PLEASE RETURN THIS FORM TO:

☐ Employee / Patient ☐ Department: _____

Bayfield County Administrator
PO Box 878
Washburn, WI 54891
Fax: 715-373-6153

COPY TO: DEPARTMENT FILE RETAIN: 3 YEARS

BAYFIELD COUNTY
FAMILY AND MEDICAL LEAVE
RETURN TO WORK CERTIFICATION

EMPLOYEE: PLEASE FILL OUT THE TOP PORTION, AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER. THIS CERTIFICATION MUST BE PROVIDED TO THE COUNTY ADMINISTRATOR PRIOR TO YOUR RETURN TO WORK.

Employee:

Employee's Department:

RETURN COMPLETED FORM TO:

Bayfield County Administrator
PO Box 878
Washburn, WI 54891

Fax: 715-373-6153

HEALTH CARE PROVIDER: PLEASE COMPLETE THE FOLLOWING AND RETURN DIRECTLY TO THE COUNTY ADMINISTRATOR'S OFFICE (LISTED ABOVE) PRIOR TO THE RETURN TO WORK DATE.

Please review the attached job description. Is the employee able to perform all the functions of his or her job? □ Yes □ No □ Yes, with restrictions.

Please list any restrictions or functional limitations which the department should consider:

Are the restrictions: □ Permanent □ Temporary, until (date):

Comments

Employee is released to return to work effective (date):

Name of Health Care Provider:

Specialty:

Address of Health Care Provider

Signature of Health Care Provider	Place address stamp here Date

COPY TO: DEPARTMENT FILE RETAIN: 3 YEARS