

Certification of Adoption or Foster Care
For Family and Medical Leave Act (FMLA)



Section I: For Completion by EMPLOYER

INSTRUCTIONS: Ensure that Sections I and II are completed before giving this form to the professional/agency.

Employer: Webster Groves School District Contact Number: (314) 961-1233 Fax: (314) 918 – 4671

Employee’s job title: _____ Regular work schedule: _____

Section II: For Completion by EMPLOYEE

INSTRUCTIONS: Ensure that Sections I and II are completed before giving this form to the professional/agency. By signing this form, you represent that the information provided is true and correct. Unless advised otherwise, you have 15 calendar days to return this form.

Employee’s name: _____

Length of time requested for leave: _____

Qualifying event for which bonding leave is being requested: Adoption Foster Care

Employee Signature: _____ Date: _____

Section III: For Completion by the PROFESSIONAL/AGENCY

INSTRUCTIONS: Please provide the following information and be sure to sign the form representing that the information provided is accurate.

Professional/Agency Name: _____

Address: _____

Telephone: _____ Fax: _____

Actual or anticipated date of placement: _____

Signature of Professional/Agency Official: _____ Date: _____