

# LA CROSSE COUNTY CHILD SUPPORT AGENCY

LAW ENFORCEMENT CENTER  
333 VINE STREET, ROOM 1701  
LA CROSSE, WI 54601  
PHONE (414) 615-2594  
FAX (608) 785-5760

## Placement/Visitation Schedule

Mother's name: \_\_\_\_\_ IVD Case # \_\_\_\_\_

Father's Name: \_\_\_\_\_ IVD Case # \_\_\_\_\_

Child Support Worker Name: \_\_\_\_\_

Please X which overnights the child spends with each parent. Utilize second week if two week placement schedule is being exercised.

If some other arrangement is exercised, indicate the **total number of overnights** each parent has annually below.

	Mother		Father	
	Week 1	Week2	Week 1	Week2
M	_____	_____	_____	_____
T	_____	_____	_____	_____
W	_____	_____	_____	_____
H	_____	_____	_____	_____
F	_____	_____	_____	_____
Sa	_____	_____	_____	_____
Su	_____	_____	_____	_____
Total	_____	_____	_____	_____

\*\*If a one week schedule, multiply each total by 52 and enter below. If two week schedule, multiply by 26 and enter total below. The annual # of days must equal 365.

Total Mother \_\_\_\_\_ (+)plus Total Father \_\_\_\_\_ = 365 days

Specify any visitation related to holidays and summer:

Holidays: \_\_\_\_\_

Summer visitation: \_\_\_\_\_

If placement/visitation is court ordered is the order being followed? Y \_\_\_ N \_\_\_

Explain if No: \_\_\_\_\_

Person completing this form: \_\_\_\_\_

Signature

Date