

LA CROSSE COUNTY CHILD SUPPORT AGENCY

ADMINISTRATIVE CENTER
400 North FOURTH STREET, ROOM 2160
LA CROSSE, WI 54601
PHONE (608) 785-9564
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.

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

**multiply each total by 52 if one week schedule or 26 if two week schedule to calculate the annual # of days

Total Annual: Mother _____

Father _____

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