UNIVERSITY OF WISCONSIN SYSTEM

EMPLOYEE REQUEST FOR FAMILY AND/OR MEDICAL LEAVE

SECTION 1: For completion by the EMPLOYEE

Employee Name and Employee ID:	
UW Institution: UW-_____	Division/Dept:
Work Phone Number:	Mobile/Home Phone Number:
Email:	

Reason for Leave (Complete all applicable):

☐ **Medical Leave for Employee's Own Serious Health Condition**

☐ **Family Leave To Care for Family Member with Serious Health Condition - Additional Information needed:**
Name and Address of Family Member:

Relationship to Employee*:_____ *For domestic partnership, complete section 2 on the back of this form.

Birth/Adoption/Foster Placement Leave - Additional Information needed:
- ☐ Birth of My Child
- ☐ Placement of a Child with me for Adoption/Pre-Adoptive Foster Care
- ☐ Placement of a Child with me for Foster Care

Anticipated Date of Birth or Placement: _____ Actual Date of Birth or Placement: _____

Military Family Leave - Additional Information needed:
- ☐ For a Qualifying Exigency
- ☐ To Care for Military Servicemember with Serious Health Condition

Name of Servicemember: _____ Relationship to Employee: _____

Leave Duration and Type:

Leave is expected to be (select the most appropriate box):

☐ For a continuous block of time (several continuous days, weeks or months off work).

☐ For a reduced work schedule (change in work schedule needed—fewer hours per day or fewer hours per week).

☐ On an intermittent basis (periodic time off that is not usually expected to be the same days or time off from week to week; examples may be time off for flare-ups of a medical condition and/or for ongoing medical treatment/appointments).

If intermittent or reduced-leave schedule is being requested, please explain why it is needed and the proposed leave schedule:

Anticipated Begin Date of Leave: _____

Anticipated End Date of Leave: _____

SUBSTITUTION OF PAID LEAVE: Please indicate if you would like to use paid leave during your absence and how many hours you plan to use (to the extent provided by law and workplace leave policies). Attach a completed leave report if required.
- ☐ Vacation/ Vacation Carryover/Banked Leave (_____ hours)
- ☐ Sick Leave (_____ hours)
- ☐ Personal/Floating Holiday (_____ hours)
- ☐ Comp Time/Other (_____ hours)

I certify that the above information is true and correct to the best of my knowledge. I authorize the appointing authority to obtain any necessary information regarding my request for family and medical leave.

Employee Signature: _____ Date: _____

SECTION 2: For completion by the EMPLOYEE who is taking leave to care for a domestic partner or a domestic partner's parent(s) ONLY

Effective June 30, 2009, employees are allowed take up to two weeks WFMLA leave to care for a domestic partner or a domestic partner's parent(s) who is suffering from a serious health condition. Employees can exercise this right under WFMLA as either a registered or unregistered domestic partner.

In order to be eligible to take WFMLA leave under these provisions, you must satisfy one of the two following sets of requirements. Please check the box that applies to your domestic partnership:

☐ I have a **registered domestic partnership** with the Register of Deeds in a county in the state of Wisconsin.

☐ I am in an **unregistered domestic partnership**. I am in a relationship with another individual and we satisfy the following requirements:

We are both at least 18 years old and otherwise competent to enter into a contract;
Neither of us is married to, or in a domestic partnership with, another individual;
We share a common residence;
We are not related by blood in any way that would prohibit marriage under the Wisconsin law;
We consider ourselves to be members of each other's immediate family; and
We agree to be responsible for each other's basic living expenses.

Certification of Domestic Partnership for WFMLA Purposes Only:

I certify that _____ is my domestic partner.
(Name of Domestic Partner)

Employee Signature: _____ Date: _____

For Employer Use Only

Leave Request is:
☐ Approved (Circle: FMLA/ WFMLA / Both)
☐ Not approved (explain below):

Authorizing Signature: _____ Date: _____

If leave request is not approved, please explain reason for denial of request: