UNIVERSITY OF WISCONSIN - MILWAUKEE
FAMILY OR MEDICAL LEAVE REQUEST FORM

Name: ______________________ Social Security Number: ______________________

Home Address: ______________________ Department: ______________________

______________________ Department Address: ______________________

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City State Zip

Home Telephone Number: ______________________ Work Telephone Number: ______________________

DATES OF LEAVE REQUESTED: From: ______________________ To: ______________________

REASON FOR LEAVE:

☐ The birth of my son or daughter and to care for such child

Actual or expected date of birth: ______________________

☐ The placement of a son or daughter with me for adoption or foster care

Actual or expected date of placement: ______________________

☐ To care for my spouse, son, daughter, or parent (circle one) who has a serious health condition (Physician's or practitioner's certification may be required)

☐ My own serious health condition (Physician's or practitioner's certification may be required)

Explain the need for the leave. (Describe the intermittent leave schedule if requesting a reduced schedule.):

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SUBSTITUTION OF PAID LEAVE:

☐ Vacation ______ Hours

☐ Personal/Floating Holiday ______ Hours

☐ Sick Leave ______ Hours

☐ Other (specify) ______ Hours

I certify that the above information is accurate and complete. I authorize the appointing authority to obtain any necessary information regarding my request for family or medical leave.

EMPLOYEE SIGNATURE: ______________________ DATE: ______________________

FOR OFFICE USE ONLY: Leave request is:

☐ APPROVED

☐ NOT APPROVED (Explanation on reverse side)

Approved leave will qualify under FMLA/WFMLA or other leave provisions to the extent that the employee meets the requirements for eligibility.

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Supervisor/Director/Chair Date

Distribution: Employee, Personnel Representative, Official Personnel File, Benefits Office