UNIVERSITY OF WISCONSIN SYSTEM
EMPLOYEE REQUEST FOR FAMILY AND/OR MEDICAL LEAVE

SECTION 1: For completion by the EMPLOYEE	
Employee Name:	
Employee Home Address:	
Home Phone Number:	Work Phone Number:
Email:	
UW Institution:	Division/Dept:
Work Address:	

Reason for Leave (Check all applicable):

- ☐ Birth/Adoption/Pre-Adoptive Foster Care
- ☐ Foster Placement
- ☐ Employee's Own Serious Health Condition (may require medical certification)
- ☐ To Care for Family Member (including domestic partner or domestic partner's parent), Military Servicemember, or Veteran with Serious Health Condition* (may require medical certification)
- ☐ For a Qualifying Exigency due to a military deployment to a foreign country of a spouse, son, daughter or parent in the regular or reserve armed forces (certification may be required)

** When Family and Medical Leave is needed to care for a family member, servicemember, or veteran, you must state the care you will provide and an estimate of the time period during which this care will be provided, including a schedule of intermittent leave or leave on a reduced work schedule, if requested.*

Anticipated Begin Date of Leave:	**Anticipated End Date of Leave**:

Briefly Explain Reason for Leave. If the leave is to care for someone, or for a military qualifying exigency, please indicate the other person's name and your relationship to that person. If leave is to care for a domestic partner or a domestic partner's parent(s), please complete and sign the back of this form.

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 (_____ hours)
- ☐ Vacation Carryover (_____ hours)
- ☐ Personal/Floating Holiday (_____ hours)
- ☐ Other: _____ (_____ hours)
- ☐ Sick Leave (_____ hours)
- ☐ Sabbatical/ALRA (_____ hours)
- ☐ Comp Time (_____ hours)

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: