State of Wisconsin
Office of State Employment Relations
Division of Compensation and Labor Relations

FAMILY AND MEDICAL LEAVE - EMPLOYEE REQUEST

SECTION 1: For completion by the EMPLOYEE

Employee Name:	
Employee Home Address:	
Home Phone Number:	Work Phone Number:
Email:	
State Agency:	Division/Office:
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) or Military Servicemember with Serious Health Condition* (may require medical certification)
- ☐ For a Qualifying Exigency due to the military active duty status or call to active duty status of a spouse, son, daughter or parent (certification may be required)

** When Family and Medical Leave is needed to care for a family member or servicemember, 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 leave is to care for someone, please indicate the name of and relationship to the person who needs care. If leave is to care for a domestic partner or a domestic partner's parent, 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, labor agreement, and workplace leave policies). Attach a completed leave report if required.

- ☐ Vacation (_____ hours)
- ☐ Personal/Floating Holiday (_____ hours)
- ☐ Compensatory Time (_____ hours)
- ☐ Sabbatical (_____ hours)
- ☐ Sick Leave (_____ hours)
- ☐ Other: _____ (_____ 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 ONLY.

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

In order to be eligible to take Wisconsin FMLA leave under these provisions, you must satisfy one of the following 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 all of 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 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 Wisconsin FMLA 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: