Department of Employee Relations
May 11, 2009

City of Milwaukee
Request for Family or Medical Leave
Under the Federal FMLA and/or Wisconsin FMLA

Please submit this form and medical certification form completed by your health care provider, as required, to your departmental leave administrator. If any information on this request form or the medical certification form is incomplete, your leave administrator will notify you and you will be given 7 calendar days to provide the missing information. Your department will notify you in writing whether your request is approved or denied. Please complete this form for each instance of leave requested.

EMPLOYEE INFORMATION

Name		PeopleSoft ID#	
Department		Job Title	
Division		Email	
Home Phone		Mobile Phone	

TYPE OF LEAVE

☐ **Medical leave for my own serious health condition: (specify)**

☐ **Family leave for the:**
- ☐ Birth of my son or daughter
- ☐ Placement of a child with me for adoption
- ☐ Placement of a child with me for foster care (federal FMLA only)

Anticipated date of birth or placement: _____

☐ **Family leave to care for family member with a serious health condition**

Family member's full name: _____ Family member's date of birth _____

Relationship to you: ☐Spouse ☐Parent ☐Son ☐Daughter ☐Parent-in-law *(Wisconsin FMLA only)*

Family member's address: _____ *(Optional)*

AMOUNT OF LEAVE:

List Month/Day/Year in appropriate columns	UNPAID LEAVE	VACATION	COMPENSATORY TIME	SICK LEAVE
FROM:				
TO:				
TOTAL HOURS:				

EMPLOYEE CERTIFICATION AND SIGNATURE

I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation of the reason for leave or any of the facts supporting the need for leave will result in denial of the leave and disciplinary action up to and including discharge.

Employee Signature:	Date:
Supervisor's Initials: *(if required by department)*	Date: