CITY OF WAUPACA

FAMILY AND MEDICAL LEAVE ACT
EMPLOYEE REQUEST FORM

GENERAL INFORMATION

NAME: _____ SSN: _____

DEPARTMENT: _____

_____ _____
Home Address Telephone

_____
City/State/Zip

REASON FOR LEAVE

- ❑ Birth/Adoption/Pre-Adoptive Foster Care
- ❑ Foster placement
- ❑ Employee's own serious health condition (Medical certification will be required.)
- ❑ To care for family member with serious health condition* (Medical certification will be required.)

*NAME OF FAMILY MEMBER AND EXPLANTION OF RELATIONSHIP: (When Family and Medical Leave is needed to care for a seriously ill family member, the employee shall state the care s/he will provide and an estimate of the time period during which this care will be provided, including a schedule if intermittent leave or leave on a reduced work schedule is requested.)

Anticipated dates/duration of leave: _____

Briefly explain reason for leave request: _____

_____

_____

_____

_____

SUBSTITUTION OF PAID LEAVE
(To the extent provided by law.)

- ❑ Annual Leave _____ Hours
- ❑ Personal Holiday _____ Hours
- ❑ Sick Leave (if eligible) _____ Hours
- ❑ Other (specify) _____ Hours

Attach completed vacation and/or sick leave request form.

CERTIFICATION

I certify that I have received information on the city's FMLA Policy, and that I understand, agree to, and meet the requirement and conditions of the state of Wisconsin and Federal Family and Medical Leave Acts. I authorize the city of Waupaca to obtain any necessary information regarding my request for family and medical leave.

_____

Employee Signature Date

FOR CITY USE ONLY:

Request for leave is:

❑ Approved (State/Federal/Both) Employee's hire date:

_____

❑ Not approved

If not approved, why:

_____

_____

_____

_____

_____

Approved by:

_____

_____

Date

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