Housing Authority of the City of Milwaukee
REQUEST FOR FAMILY OR MEDICAL LEAVE and DEPARTMENT REVIEW UNDER THE FEDERAL FMLA AND/OR WISCONSIN FMLA

11/04/10

EMPLOYEE INFORMATION			
Name		Job Title	
Department		Email	
Home Phone		Mobile Phone	

TYPE OF LEAVE

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

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

Name of family member: Address:

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

If son or daughter, date of birth:

☐ **Family leave for the:**
- ☐ Birth of my child
- ☐ 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:_____ Anticipated date of birth or placement:_____

☐ Military Family Leave to care for a covered servicemember with a serious health condition**:**

Name of Servicemember:_____ Relationship to Employee:_____

☐ Military Family Leave Exigency Leave**:**

Name of Servicemember:_____ Relationship to Employee:_____

AMOUNT OF LEAVE

(List Month/Day/Year)	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 on Receipt of Form*	*Date of Receipt*

Employee Name: _____ Date:_____

DEPARTMENT REVIEW

Department FMLA leave administrator to complete appropriate sections.

☐ Your Request for FMLA Leave is approved.

☐ Your Request for FMLA Leave as indicated on your certification is approved for the following period of time:

_____

According to the certification, the duration and frequency that is authorized for time away from work is:

_____

Please note that should your need for time off exceed the frequency or duration shown above, or extend beyond the approval period, you will need to provide another certification.

☐ Additional information is needed.

Please provide the information requested below no later than _____ *(at least 7 calendar days)* unless it is not practical under the particular circumstances or leave may be denied. The certification you have provided is not complete and sufficient to determine eligibility for FMLA. Please provide the following information:

_____

Other:

_____

☐ Your Request for FMLA is not approved because:

- ☐ You have not met the FMLA service requirement.
- ☐ You have exhausted your FMLA leave entitlement in the applicable 12-month period.
- ☐ Your request for leave is not covered by the Federal FMLA and/or Wisconsin FMLA. *Comment:*

_____

- ☐ *Other:*

_____

Other Information:

☐ We are exercising our right to have you obtain a second or third opinion medical certification at our expense and we will provide further details at a later time.

☐ You will be required to present a release-to-duty certification from your health care provider to be restored to employment. A list of the essential functions of your job ☐ **is** ☐ **is not** attached. If attached, the release-to-duty certification must address your ability to perform these functions. If such certification is not received in a timely manner, your return to work may be delayed until certification is provided.

Approving Officer's Signature (leave administrator)	*Approving Officer's Title*	*Date*

Copy to Employee Supervisor:		
	Employee Supervisor Name	*Employee Supervisor Title*

Employee Name: _____ Date:_____