

**UNIVERSITY OF WISCONSIN - MILWAUKEE  
FAMILY OR MEDICAL LEAVE REQUEST FORM**

---

Name: \_\_\_\_\_ Person ID Number\*: \_\_\_\_\_

Home Address: \_\_\_\_\_ Department: \_\_\_\_\_

\_\_\_\_\_ Department  
Address: \_\_\_\_\_

\_\_\_\_\_ City State Zip

Home Telephone Number: \_\_\_\_\_ Work Telephone Number: \_\_\_\_\_

DATES OF LEAVE REQUESTED: From: \_\_\_\_\_ To: \_\_\_\_\_

- REASON FOR LEAVE:  The birth/care for my child; or the placement of a child for adoption or foster care  
Actual or expected date of birth/placement: \_\_\_\_\_
- To care for my seriously ill or injured spouse, son, daughter, parent or next of kin who served in the Armed Forces (Physician's or practitioner's certification may be required)
- To care for my spouse, son, daughter, or parent (circle one) who has a serious health condition (Physician's or practitioner's certification may be required)
- My own serious health condition (Physician's or practitioner's certification may be required)

Explain the need for the leave. (Describe the intermittent leave schedule if requesting a reduced schedule.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SUBSTITUTION OF PAID LEAVE:  Vacation \_\_\_\_\_ Hours

Personal/Floating Holiday \_\_\_\_\_ Hours

Sick Leave \_\_\_\_\_ Hours

Other (specify) \_\_\_\_\_ Hours

I certify that the above information is accurate and complete. I authorize the appointing authority to obtain any necessary information regarding my request for family or medical leave.

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

---

FOR OFFICE USE ONLY: Leave request is:  APPROVED

NOT APPROVED (Explanation on reverse side)

Approved leave will qualify under FMLA/WFMLA or other leave provisions to the extent that the employee meets the requirements for eligibility.

Supervisor/Director/Chair \_\_\_\_\_ Date \_\_\_\_\_

Distribution: Employee, Personnel Representative, Benefits Office