FMLA LEAVE OF ABSENCE REQUEST FORM

HR 1500-B

Dept of Administration-Human Resources Division
Waukesha County Administration Center
515 W. Moreland Blvd.
Waukesha, WI 53188
Phone: 262-548-7044
Fax: 262-896-8272
HR@waukeshacounty.gov

To be eligible for Wisconsin and/or Federal Family and Medical Leave: under Wisconsin FMLA you must have been employed with Waukesha County at least 52 consecutive weeks and worked at least 1,000 hours (time spent on paid or unpaid leave counts in determining the 1,000 hours); under Federal FMLA, you must have been employed at least 12 months (not necessarily consecutive; based on a 7 year look-back) and worked at least 1,250 hours (time spent on paid or unpaid leave does not count in determining the 1,250 hours).

Please refer to the County's Leaves of Absence Policy 1500 for complete details and other information pertaining to an FMLA Leave.

INSTRUCTIONS:

1. Requests should be made at least 30 calendar days in advance, or as soon as practical for unforeseen medical leaves following your department's usual and customary leave procedure notice requirements. Failure to give timely notice, and/or submit the FMLA Leave Request Form, and/or requisite certification and/or affidavit form, may result in the delay or denial of FMLA.

2. You are to complete the employee portion of the FMLA Request Form and submit it to your supervisor/department with any required certification and/or affidavit form.

   a. For your own serious health condition leave. It is recommended you provide your treating health care provider a copy of your classification specification to assist the provider in completing the FMLA Health Care Provider Certification Form.

      Your classification specification may be found at https://www.governmentjobs.com/careers/waukeshacounty. Click on "Menu" in the upper left side, then choose "Class Specifications"; from there you can either scroll through the list or type in the title in the "Search" field.

   b. Certification and/or Affidavit Form; to be submitted to your supervisor/department:

      - Due within 15 calendar days of the effective date of leave:
        - HR-1500-C FMLA Health Care Provider Certification Form (for your own or an eligible family member's serious health condition)
        - HR-1500-D Federal FMLA Certification for Military Qualifying Exigency Form
        - HR-1500-E Federal FMLA Certification for Serious Injury or Illness of a Current Servicemember (Military Caregiver Leave)
      - Due at time of submittal of the FMLA Request Form (if applicable):
        - HR-1500-F Federal FMLA "*in loco parentis*" Affidavit Form
        - HR-1500-G Wisconsin FMLA Domestic Partnership Affidavit Form

3. Your supervisor/department will review the document(s) for completion and submit to the Human Resources Division where the request is reviewed for approval. Human Resources will provide you and your supervisor/department with leave designation information. Barring any extenuating circumstances, which will be reviewed on a case-by-case basis, time off for FMLA may be approved up to fifteen (15) calendar days retroactive from the date of the supervisor/department's signature.

4. If you receive written notification from HR that the documentation is incomplete, vague, and/or insufficient, you will have seven (7) calendar days to cure the identified deficiencies. If you do not provide the required certification by the designated deadline, or if it determined your leave request is not covered under Wisconsin and/or Federal FMLA Leave, the leave may not be designated as FMLA Leave.

If you have any questions or concerns regarding Wisconsin and/or Federal FMLA, or the request process, please do not hesitate to contact the Human Resources Division, Monday-Friday, 8:00 am to 4:30 pm, at 262-548-7044 or via email at HR@waukeshacounty.gov.

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TO BE COMPLETED BY THE EMPLOYEE – PLEASE TYPE or PRINT LEGIBLY

Name: ________________________________ **Department:** ________________________________
First and Last Name

Date of Hire: _____/_____/_______ **Indicate if you work:** ☐ Full-Time ☐ Part-Time ☐ Temporary/Seasonal

Supervisor Name and Title: ____________________/____________________
First and Last Name / Title

Email Address while on Leave: ________________________________

Phone while on Leave: ______-________-__________

Mailing Address: ____________________/____________________/______________
Street Address / City / Zip

Does your spouse work for the County? ☐ No ☐ Yes; provide: ____________________/______________
Name / Department

TYPE OF LEAVE REQUESTED (indicate either or both and estimate leave dates):

☐ Continuous From ______/______/________ to ______/______/________

☐ Non-continuous/Intermittent From ______/______/________ to ______/______/________

CHECK APPROPRIATE REQUEST TYPE:

☐ Birth of child; Anticipated Due Date: ____/____/______

☐ Placement of child for adoption (Court documentation required); Anticipated Placement Date: ____/____/______

☐ Placement of child for foster care (as allowed under the federal FMLA; Court documentation required)
Anticipated Placement Date: ____/____/______

☐ Serious health condition of (indicate one of the following; include name for other than self). *Requires submittal of the FMLA Health Care Provider Certification Form (HR-1500-C) verifying the serious health condition for medical leave requests within 15 calendar days of the effective date of the leave; if not timely submitted, leave may be denied or delayed.*

☐ Self

☐ Child [1] Birth Date: _____/_____/______ ☐ Spouse ☐ Domestic Partner [2] (as allowed under WI FMLA)

☐ Parent [1] ☐ Parent-in-law/Domestic Partner's Parent [2] (as allowed under WI FMLA)

Name if other than self: ________________________________
First and Last Name

☐ Qualifying military exigency arising out of a family member's active duty in the Armed Forces (Requires submittal of the Federal FMLA Certification for Military Qualifying Exigency Form, HR-1500-D)

☐ Care for a covered service member/veteran (Requires submittal of the Federal FMLA Certification for Serious Injury or Illness of a Current Servicemember Form, HR-1500-E)

[1] May require Federal "*in loco parentis*" Affidavit Form (HR-1500-F) if applicable.
[2] Requires Wisconsin FMLA Domestic Partnership Affidavit Form (HR-1500-G).

SUBSTITUTION OF BENEFITS; Check Appropriate Box:

Under Wisconsin FMLA, an employee may choose to substitute paid benefits (including use of sick leave for other than their own serious health condition), take the leave as unpaid, or use any combination of paid (substituting paid benefits) or unpaid leave.

If I qualify for WI FMLA: ☐ I do not wish to substitute paid benefits ☐ I wish to substitute paid benefits; I will confer with my supervisor/department

(*Under Federal FMLA, the County requires an employee to exhaust all eligible paid benefit time prior to taking the leave as unpaid.*)

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

________________________________ ______/______/________
Employee Signature Month Day Year

TO BE COMPLETED BY THE DEPARTMENT REPRESENTATIVE

☐ Requisite forms attached; they have been reviewed and appear to be fully completed.

____________________/____________________ ________/________/________
Print Name / Sign Month Day Year