



DEPARTMENT OF EMPLOYEE RELATIONS

Revised: 7/12/2022

CITY OF MILWAUKEE FMLA PAYROLL FORM

Under the Federal FMLA and/or Wisconsin FMLA

Please complete this form for each instance of leave used and provide to your departmental FMLA administrator or other designated employee. A new payroll form is to be completed for each pay period in which FMLA leave is utilized, or for each period of continuous leave beyond one pay period. You will be notified if your leave is denied or if new documentation is required. For FMLA leave related to care of a covered military service member, or for military exigency leave related to a family member's military deployment, please complete and submit the City of Milwaukee FMLA Payroll Form for Military Caregiver and Exigency Leave. **FMLA leave taken as 069 time (payroll code 269) may only be used for the employee's own scheduled appointments with their treating healthcare provider.**

EMPLOYEE INFORMATION

Name:	PeopleSoft ID #:
Department:	E-Mail:
Division:	Home Phone: ()
Job Title:	Mobile Phone: ()

TYPE OF LEAVE

Medical Leave for Employee's Own Serious Health Condition.
If approved for leave for multiple conditions please identify which condition(s) you utilized leave for _____

Family Leave to Care for Family Member with a Serious Health Condition

Name of Family Member: _____

Address: _____ (City/State)

Relationship to Employee: _____ If Son or Daughter, Date of Birth: _____

Indicate Spouse, Domestic Partner, Parent, Son, Daughter, Parent-in-Law, or Parent of Domestic Partner**

**Domestic Partner for WFMLA only: as defined in section 40.02(21c) or section 770.01(1) of the Wisconsin Statutes*

- Family Leave For:
- 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: _____ Actual Date of Birth or Placement: _____

LEAVE USAGE

I utilized/will utilize scheduled leave on a continuous basis from:

Dates of leave: _____

I utilized/will utilize scheduled leave for a reduced schedule on:

Dates of leave: _____

I utilized/will utilize scheduled leave for scheduled appointments on:

Dates of leave: _____

I utilized/will utilize leave for unforeseen episodes (i.e. flare-ups or other unexpected need) on:

Dates of leave: _____

AMOUNT OF LEAVE REQUESTED

		<i>Sick Leave 243</i>	<i>Vacation 242</i>	<i>Holiday 245</i>	<i>TVA 254</i>	<i>SLCIP 262</i>	<i>Comp Time 266</i>	<i>Misc. 269</i>	<i>Unpaid 299</i>
<i>Dates</i>	From:								
	To:								
Total Hours:									

EMPLOYEE CERTIFICATION AND SIGNATURE

I hereby certify that the information given 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 may result in denial of the leave and disciplinary action up to and including discharge:

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Employee Signature

Date

- Reviewed by FMLA Administrator on _____
- Reviewed by Supervisor on _____
- Payroll File