



FMLA/EFMLEA LEAVE REQUEST

****This form should not be used for leaves occurring after December 31, 2020. ****

EMPLOYEE NAME (Print): _____

POSITION: _____

Reason for Leave Request (check one):

- Birth or adoption of child, or foster care placement
Expected date of event: _____
- (EFMLEA) You are unable to work (or telework) because you are needed to care for your son or daughter under 18 years of age because your child's school or place of care has been closed, or your son or daughter's child care provider is unavailable, due to the public health emergency with respect to COVID-19 declared by a Federal, State, or local authority. ("EFMLEA") (For purposes of this provision, "child care provider" means a provider who receives compensation for providing child care services on a regular basis, including an "eligible child care provider" as defined 42 U.S.C. 9858n; and "school" means an "elementary school" or "secondary school" as such terms are defined in 20 U.S.C. 7801.
- Care of self, due to a serious health condition. State condition: _____
- Care for spouse, parent or child with a serious health condition. State condition: _____
- Care for a child *age 18 or over* who cannot care for himself or herself because of a serious health condition and who is "incapable of self-care" because of mental or physical disability that limits one or more "major life activities". State medical condition: _____
- Care for registered domestic partner with a serious health condition. State condition: _____
- Care for injured service member in your family or next of kin. State condition: _____
- Care for qualifying exigency related to military call up or active duty of a family member.

Identify exigency: _____

If leave is taken for care of a family (including EFMLEA) or service member or qualified exigency, please provide full name, relationship, address and age of family or service member:

For EFMLEA, please provide name, address and telephone number of school or eligible child care of the child for whom you are seeking to take leave:

Start Date of Anticipated Leave: _____ Expected Return Date: _____

Will leave be on an intermittent or reduced leave schedule? (EFMLEA only with agreement of [Organization])

YES NO (Detail requested reduced/intermittent schedule and reason for schedule.)

For leave for the birth/adoption of a child, leave for my serious health condition or the serious health condition of a family member, I would like to be paid for my leave by using:

- Paid sick leave
- Paid vacation time
- Paid Personal holiday
- Compensatory Time
- Other: _____

(Note: This may not be applicable if you are on worker's compensation.)

For my first ten work days of EFMLEA leave I would like to be paid for my first ten work days of leave by using:

- Paid sick leave
- Paid vacation time
- Paid Personal holiday
- Compensatory Time
- Other: _____

Employee Certification and Signature

I understand that each time I need to take time off for FMLA leave I should advise Human Resources as soon as possible of the need for that specific type of leave. If I am on intermittent leave, I must inform my supervisor every time an absence is for FMLA purposes. I hereby certify that the information given above is true, complete and correct to the best of my knowledge. I understand that intentionally falsifying this FMLA leave request or misrepresenting any facts regarding the need for leave can result in denial of leave and discipline up to and including discharge.

Employee Signature: _____ Date Submitted: _____

Return Form to Amy Krogman, Administrative Specialist/HR Assistant
Mail: City Hall, 207 W. 6th Street, Marshfield, WI 54449
Email: amy.krogman@ci.marshfield.wi.us
FAX: 715-384-9310