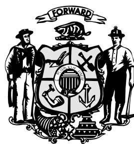
STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DIVISION OF PERSONNEL MANAGEMENT
DOA-15354 (C4/2020)



EXPANDED FAMILY AND MEDICAL LEAVE (EFMLA) REQUEST

TO BE COMPLETED BY EMPLOYEE

NOTE TO EMPLOYEE: All requests for FMLA must be submitted as promptly as possible after you become aware of a need for leave. Failure to notify your employer in a timely manner according to agency procedures may result in a delay in the processing of your FMLA. You must continue to follow your work unit's existing attendance policy and call-in procedures.

EMPLOYEE NAME (Last, First, M.I.)	POSITION TITLE	STATE AGENCY / DIVISION

EMPLOYEE ID#	EMPLOYEE STATUS	IS YOUR POSITION FULL TIME?	If less than full time, number of hours typically worked in a week. ______
	☐ Permanent ☐ Project ☐ LTE ☐ Seasonal ☐ Trainee ☐ Unclassified	☐ Yes ☐ No	

SUPERVISOR NAME	SUPERVISOR EMAIL

EMPLOYEE CONTACT INFORMATION DURING LEAVE

STREET / PO BOX ADDRESS (include Apt. #)	CITY	STATE	ZIP

EMPLOYEE TELEPHONE (Include Area Code)	EMAIL ADDRESS

REASON FOR LEAVE (choose one):

☐ My child's elementary or secondary school is closed due to a public health emergency.

Name of school child previously attended: ______________________

☐ My child's daycare facility is unavailable due to a public health emergency.

Name of child care facility child previously attended: ______________________

I certify there is no other suitable person available to care for the child during this time. - ☐ Yes

ANTICIPATED DATES OF LEAVE:

Beginning Date: End Date:

**Beginning date should be the first date, on or after 4/1/2020, you missed all, or part of a regularly scheduled work shift related to this request*

In what manner are you anticipating using leave as it relates to this request? *Please check all that apply*

☐ A continuous block of leave

☐ Intermittent – Irregular – time off from work at irregular intervals due to an actual necessity

☐ Intermittent – Reduced Schedule – a predictable schedule and reducing the number of hours worked per week

Describe requested schedule of leave and/or frequency and duration of intermittent or reduced leave, if applicable:

LEAVE USAGE: *After the first 10 working days, which are unpaid, Expanded FMLA is paid at 2/3 of your normal rate, with a cap of $200 per day. You may choose to substitute other leave during this first 10 working day. Please select as many as may apply.*

☐ Sick Leave ☐ Vacation ☐ Personal Holiday ☐ Legal Holiday ☐ Sabbatical ☐ Unpaid Leave ☐ Comp Time ☐ Emergency Paid Sick Leave

Employee Acknowledgement:

I understand that if my leave is approved, my time away from work will be charged against my leave entitlement under the federal FMLA. I acknowledge the Emergency Family and Medical Leave Expansion Act does not increase the total allotment of FMLA leave available in the calendar year and does not increase leave entitlements provided under Wisconsin FMLA.

EMPLOYEE SIGNATURE	DATE SIGNED

FOR HUMAN RESOURCES USE ONLY

LEAVE REQUEST IS ☐ APPROVED (approved under): ☐ EFMLA OR ☐ DENIED

IF APPROVED BEGINNING DATE ____________ END DATE ____________ FREQUENCY ____________ DURATION ____________

REASON FOR DENIAL:

HUMAN RESOURCES SIGNATURE	DATE SIGNED	FMLA REQUEST #

DISTRIBUTION: Original – Designated HR File; Copy – Employee