This is a fill-in form. Please click on the appropriate area to enter information. Tab between fields and PRINT when completed.

STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DIVISION OF PERSONNEL MANAGEMENT
DOA-15309 (C07/2018)
S. 230.36, WIS. STATS.
PREVIOUSLY OSER-DCLR-22

EMPLOYEE MANAGEMENT
101 E. WILSON ST, 4TH FL
MADISON, WI 53703

REQUEST FOR LEAVE OF ABSENCE WITH PAY DUE TO INJURY

Employee name:	Mailing address (work):	Classification:
Agency:	Employing unit:	Headquarters city:

Location where injury occurred:	Time of injury:	Date of injury:

Worker's compensation claim filed? ☐ Yes ☐ No	Probable duration of disability:

Has a previous request for 230.36 benefits been filed for this injury? ☐ Yes ☐ No

Describe nature of injury:

Describe circumstances resulting in the injury:

If injury involved other persons, give names and indicate whether employee, patient, inmate, or other:

Names and addresses of witnesses:

Attending physician's name and address:

I certify that to the best of my knowledge these statements are true and that the injury was incurred in the performance of my duties. If benefits are denied, I understand that if I am an employee covered by a collective bargaining agreement, I may appeal in accordance with applicable agreement provisions. I further understand that if I am an employee not covered by a collective bargaining agreement, I may appeal directly to the Commission (WERC) in accordance with Wisconsin Human Resources Handbook Chapter 430.050 within 14 days of the date of the decision.

Date:	Signature of employee:

SECONDARY LEVEL RECOMMENDATION:
☐ Approved ☐ Denial of benefits – If denial is recommended, state reasons:

I certify that I have investigated/reviewed this request.

Date:	Signature of authorized representative:

AGENCY ACTION:
☐ Approved ☐ Denied – If denied, state reasons:

Date:	Signature of appointing authority:

DISTRIBUTION: ___Employee P-File ___Region DPM HR ___Agency ___Secondary Level __Employee

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