Medical Leave Request

School of Medicine and Public Health

Please return this form to your department Human Resources within 24 hours of discussing a medical leave.

Name:			
Empl ID:		Preferred Phone #:	
Department:		Job Title:	

Reason for Leave:

- ☐ Birth of a child
- ☐ Placement with employee of a child for adoption or foster care
- ☐ Employee's own serious health condition
- ☐ To care for family member with serious health condition
- ☐ A qualifying exigency for a military family member on covered active duty
- ☐ To care for a covered service member with a serious injury or illness

Anticipated Dates of Leave:

☐ Continuous Begin Date _____ End Date_____

☐ Intermittent Begin Date _____ End Date_____

Estimated Frequency: _____ times/week OR _____ times/month

Estimated Duration: _____ hours/episode OR _____ days/episode

☐ Reduced Work Schedule Begin Date _____ End Date_____

Estimated Frequency: _____ times/week OR _____ times/month

Estimated Duration: _____ hours/episode OR _____ days/episode

Leave Options:

- ☐ I will use paid leave.
- ☐ I will use unpaid leave.
  - * Leave Without Pay form required. See right →
- ☐ I will use a combination of paid and unpaid leave.
  - * Leave Without Pay form required. See right →
- ☐ I am unsure and will discuss with my department HR.

Leave Without Pay Form:

http://go.wisc.edu/u14r9w

Note: Taking unpaid leave will reduce your allocations of paid leave. Please discuss questions with your department HR.

☐ The employee's supervisor has been notified of this leave request (either by employee or HR).

_____ _____

Employee's Signature Date

_____ _____

Department HR Signature (Optional) Date

_____ _____

SMPH HR Signature Date

Leave request is _____ Approved _____ Not Approved

Revised: 05/18/2015