

City of Madison
FAMILY AND MEDICAL LEAVE OF ABSENCE (FMLA)
APPLICATION INSTRUCTIONS AND INFORMATION FOR EMPLOYEES AND DEPARTMENTS

(See City of Madison APM 2-21, Family and Medical Leaves of Absence)

For questions or concerns about the application process or filling out the form, contact Human Resources (HR) at 266-4615 or email hr@cityofmadison.com.

APPLICATION PAGE 1:
EMPLOYEE PREPARES AND SUBMITS TO HR WITH MEDICAL DOCUMENTATION

Read and complete form	Read instructions and provide all the information requested.
Telephone	Provide home phone number. Show other numbers that may help Human Resources contact you at work or home (cell phone, work phone)
Check box: Use of leave	Show whether family leave was taken in the last year.
Check box showing qualifying reason and family relationship	Show the reason (basis) for family leave—one of seven possible. Use another application if there is a second qualifying reason. Only listed family relationships qualify for FMLA.
Read and complete form	Read instructions and provide all the information requested.
Employee: Submit Application Page 1 and supporting medical documentation to City Human Resources Dept, Compensation/Benefits, 210 Martin Luther King, Jr. Blvd, Room 501, Madison WI 53703 in an envelope marked “Confidential.”	

APPLICATION PAGE 2:
EMPLOYEE PREPARES AND SUBMITS TO CITY DEPARTMENT, THEN DEPARTMENT SUBMITS TO HR

Name, Department	Provide again.
Method of Leave Requested, Dates/Schedule	Check how leave is to be scheduled and explain if needed. Example: Consecutive Leave 1/5/09 to 1/16/09 Intermittent Leave 1/19/09 to 3/20/09 Explanation: Want to work half days after 1/19 if doctor allows.
Request for AWOP or Substitution of Paid Leave	Show specific dates and amounts. Substitution of paid time is required for some categories of FMLA and some amounts of leave.
Certification	Read, sign and date.
Employee: Submit Page 2 to your department head or designated employee (e.g., payroll clerk)	
Department Review	Department should check that the employee has provided all requested information and ask the employee for any missing information.
Qualifying length of employment and hours worked (Federal and State) and FMLA time charged	Department should check and answer Yes or No to both questions about eligibility (Federal and State) and recommend approval, modification or denial. Department Head signature is required. The department should report hours of FMLA charged that will affect current eligibility.
Department: Submit completed Application Page 2 to City Human Resources Department, Compensation/Benefits, 210 Martin Luther King, Jr. Blvd, Room 501, Madison WI 53703.	

Human Resources Approval Page (page 3): The Human Resources Department will prepare the HR Approval/Denial and Notice page and provide it to the employee with a copy of pages 1 and 2 of the application. A copy of the HR Approval/Denial and Notice page will be sent to the employee’s department and to City Payroll with copies of page 2 of the employee’s application.

NOTES FOR EMPLOYEES AND SUPERVISORS

1. When leave will be for birth or adoption of a child, the employee needs to submit the family leave application well in advance, showing the expected start date of leave and documenting eligibility. Documentation of eligibility should come from the health care or adoption provider and show the employee name, that the employee is the expectant mother or father, and expected date of birth or adoption. The employee's department and the Human Resources Department must be notified of the actual date of birth or adoption as soon as possible after the event.
2. All leave to which an employee is entitled, including Federal FMLA, Wisconsin FMLA, and disability leave under Madison General Ordinances, will run concurrently as applicable.
3. If an employee is requesting intermittent leave for a chronic health condition, the employee will be required to submit medical certification after six (6) months of FMLA in addition to the medical certification required at the time of application.
4. An employee requesting leave to take care of a domestic partner or parent of a domestic partner must certify on the health care provider application that the domestic partner is someone as defined in the Wisconsin Statutes 40.02(21c) or 770.01(1). See APM 2-21 for more details.
5. An employee using intermittent leave must follow regular department procedures for calling in and using family leave. An employee using intermittent leave for medical appointments must make a reasonable effort to schedule such appointments around the needs of the City. This generally means that appointments will be made and the City informed at least 30 days in advance, or otherwise as soon as practicable. An employee who fails to provide 30 days notice may be required to provide an explanation for why he/she was unable to schedule the appointment without greater notice.
6. **An employee who has approved intermittent FMLA and calls in according to approved procedures should inform his/her supervisor at the time of calling in that the leave should be counted as family leave.** The City has the right to follow up on any absence for which the employee does not provide the information about whether the absence is to be considered family leave, and the employee is obligated to respond. Failure to do so will result in the absence not being covered by family leave provisions.
7. Medical information is to be sent directly to Human Resources. Supervisors and other department representatives do not have a right to inquire about the medical information, and are prohibited under the Family and Medical Leave Act from contacting an employee's health care provider to ask about an employee's medical information.
8. Employees using leave pursuant to the Federal FMLA may be required to substitute paid leave time, including sick leave, vacation time, and floating holiday time, as outlined in APM 2-21.
9. Absences may affect City employment benefits. Questions should be directed to Human Resources, 266-4615, or email hr@cityofmadison.com

An employee's original application and supporting medical documentation will be maintained in confidential medical files in the Human Resources Department.

City of Madison
APPLICATION FOR FAMILY/MEDICAL LEAVE

An employee must provide all information requested on this form. Required supporting documentation must be provided to the Human Resources Department in order for this application to be considered. Failure to provide required information may result in leave being denied. Leaves provided by the City which also qualify as Family and Medical Leave (FMLA) will run simultaneously with the leave required under the FMLA laws.

PLEASE TYPE OR PRINT IN INK

Employee Name: _____ Home Telephone: _____

Other Telephone Numbers: _____

Position Title: _____ Department: _____

Date of Application _____ Date of Hire: _____

I have have not taken family medical leave in the preceding twelve (12) month period.

ELIGIBILITY

Federal Leave: An employee must have been employed by the City for at least 12 months, which need not be consecutive months, and must have worked for at least 1,250 hours (not including paid leave) during the preceding twelve (12) months in order to be eligible for the Federal Leave entitlement. Leave taken under the Federal FMLA will be tracked on a forward-measured 12 month basis from the date of the first FMLA use.

Wisconsin Leave: An employee must have been employed by the City for at least 52 consecutive weeks, and must have been paid for at least 1,000 hours (including paid leave) during the preceding 52-week period in order to be eligible for the State Leave entitlement. Leave taken under the Wisconsin FMLA will be tracked on a calendar-year basis, per the WFMLA.

FAMILY/MEDICAL LEAVE IS REQUESTED FOR THE FOLLOWING REASON (CHECK ONE):

- Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. (Must submit "Health Care Provider Certification" to the Human Resources Department in accordance with APM 2-21.)
- The birth of a child or placement of a child for adoption with an employee and in order to care for such child. (Please submit application and Provider Certification well in advance and the expected date of birth or placement for adoption, in accordance with APM 2-21, and notify department and Human Resources of the actual date as soon as possible after birth or adoption.)
- The placement of a child with the employee for foster care and in order to care for such child. (Please send documentation verifying the placement of a foster child to the Human Resources Department, in accordance with APM 2-21.)
- In order to care for a family member who has a serious health condition (check one): (Must submit "Health Care Provider Certification" to the Human Resources Department in accordance with APM 2-21.)
 - Child
 - Spouse
 - Parent
- In order to care for a domestic partner, parent-in-law, or parent of a domestic partner who has a serious health condition. (Leave is limited to two weeks.) (Must submit "Health Care Provider Certification" to the Human Resources Department in accordance with APM 2-21.)
- In order to care for a family member who has a serious injury or illness incurred as a member of the military while in the line of duty on active duty (check one): (Must submit "Health Care Provider Certification" to the Human Resources Department in accordance with APM 2-21 and official military documentation of qualifying basis for leave.)
 - Son
 - Daughter
 - Spouse
 - Parent
 - Next of Kin
- "Qualifying exigency" arising out of a spouse's, son's, daughter's or parent's active military duty or notification of impending call or order to active duty in support of a contingency operation (check one): (Please attach documentation describing the qualifying reason, in accordance with APM 2-21.)
 - Son
 - Daughter
 - Spouse
 - Parent

Employee: Submit this Page 1 of Application to City Human Resources Department, Confidential/Benefits, with Health Care Provider Certification or documentation verifying expected date of birth or adoption.

APPLICATION FOR FAMILY/MEDICAL LEAVE: SCHEDULE, DEPARTMENT INFORMATION

Employee Name: _____ Department: _____

METHOD OF LEAVE REQUESTED, DATES/SCHEDULE

Consecutive Leave: From _____ To _____
 Intermittent/Reduced Schedule Leave: From _____ To _____ (Provide proposed schedule details)
 Reduced Schedule Leave: From _____ To _____ (Provide proposed schedule details)

Provide details and needed explanation. Note: When leave is foreseeable, the employee must ordinarily obtain approval for the proposed leave schedule at least thirty (30) days prior to the first day of leave, in accordance with APM 2-21.

REQUEST FOR AWOP AND/OR SUBSTITUTION OF PAID LEAVE

Type of Leave	Dates For Use of Leave	Number of Days Requested
<input type="checkbox"/> Absence Without Pay	_____	_____
<input type="checkbox"/> Vacation	_____	_____
<input type="checkbox"/> Sick	_____	_____
<input type="checkbox"/> Compensatory Time	_____	_____
<input type="checkbox"/> Floating Holiday/Personal Days	_____	_____

Note: Substitution of vacation, sick leave, compensatory time or floating days will be made up to the amount an employee has accumulated, and the employee shall be required to substitute such time in accordance with APM 2-21 XII.

CERTIFICATION

I certify that the information I have provided in this application is true. Any misrepresentation by me may subject me to disciplinary action. I understand that failure to supply the required information and Health Care Provider Certification(s) may result in denial of this leave application. I understand I must make arrangements with the Human Resources Department to pay for the employee portion of health insurance premiums prior to my leave.

Employee Signature: _____ Date: _____

Employee: Submit this Page 2 of application to your department head or designated employee (e.g., payroll clerk).

DEPARTMENT HEAD ELIGIBILITY ASSESSMENT

This employee has been employed for at least twelve (12) months and has worked at least 1,250 hours (not including paid leave) in the preceding 12 month period. Yes No

This employee has been employed for at least 52 consecutive weeks and has been paid for at least 1,000 hours during the preceding fifty-two (52) week period. Yes No

Note: If the answer to both preceding questions is No, this application should be denied because the employee is not eligible. Please still route to HR so we can verify.

Family Leave time used in the last year: _____

This request is: Approved Approved as Modified Denied because employee does not meet eligibility criteria above

Suggested modifications or reason for denial: _____

Department Head Signature: _____ Date: _____

Title: _____ Department: _____