Employee Responsibility: Please complete this form in its entirety and have the patient’s treating health care provider complete the Health Care Provider Certification form. Then submit both to the Office of Human Resources.

EMPLOYEE TO COMPLETE

EMPLOYEE STATEMENT:

I wish to apply for Family Medical Leave to care for (check which of the following applies):

☐ A parent/legal guardian who acted in place of my biological parent (“in loco parentis”) and was responsible for my day-to-day care and financially supported me when I was a child.

☐ A dependent for whom I am currently acting as a parent, providing day-to-day responsibilities for, caring for, and financially supporting (“in loco parentis”).

Please initial the line below if the dependent listed above is over the age of 18.

_____ I certify that the dependent listed above is over the age of 18 and is currently disabled and incapable of self-care because of a mental or physical disability as defined by the Americans with Disabilities Act.

Employee’s Signature ______________________  Date ____________________

Please return completed form to the Office of Human Resources by:

Placing in a sealed envelope marked “personal and confidential” and sending to:

Medical College of Wisconsin
Attn.: Human Resources Service Center - FMLA
8701 Watertown Plank Road
Milwaukee, WI 53226
(414) 955-8245

OR

Attaching a cover sheet marked “personal and confidential”, and faxing to:

(414) 955-0113