Milwaukee County FMLA Payroll Supplement

To be completed by Employee and returned to: fmlacenter@fmlasource.com or by fax at 877-309-0218

Please Note: This supplement is only used to show how you want your *WI FMLA time paid*. Use FMLASource's automated phone system, website, or app to report time off, and also follow your department's policy for reporting time away each time you miss work. See your FMLA approval letter for more information on how to report your time.

When you are approved for WI FMLA, you can choose how you want your accrued paid time to cover your leave.

Once you use up your approved WI FMLA, the remainder of your approved leave is covered by federal FMLA policy.

In accordance with federal policy, paid time will then be substituted in this order until each category is exhausted:
1.Sick 2. Vacation 3. Personal 4.Comp (*only if employee chooses to use it and after the previous three categories are used up), and 5.Holiday. Any remaining approved federal FMLA time off will be unpaid.

Date:

Employee Name: Department:

Clock Number: Supervisor Name:

If you are approved for WI FMLA, please indicate the number of hours you want recorded as:

_____Sick _____Vacation _____Personal _____Comp/OT_____Accrued Hol _____Without Pay

*Please note: Employees can only choose how their time will be used while on WI FMLA. Once WI FMLA time is exhausted, federal leave substitution rules are applied to the remaining approved time. Sick time cannot be used for bonding under Federal leave. An employee may choose if they want overtime used while on federal FMLA.

I choose to use my Accrued OT during my Federal FMLA: Yes_____ No _____

___Single Block of Time: Requested Start Date_____Requested End date:_____

___Intermittent:

Employee is not working overtime due to FMLA on this date	*Number of hours*	*Missed scheduled overtime due to need for FMLA*	*If yes, number of overtime hours not worked*
		Yes No	
		Yes No	
		Yes No	
		Yes No	

Employee will be applying for Short Term Disability _____Yes _____No

If Yes, date employee will begin collecting benefit _____

Employee Signature *Phone number* *Date*

This form is for Milwaukee County Payroll Use Only