



WAUKESHA COUNTY

Wisconsin Family and Medical Leave Domestic Partnership Affidavit HR-1500-G

Print Employee Name: _____

Print Name of Domestic Partner: _____

TYPE OF DOMESTIC PARTNERSHIP (Select One):

- Registered – Attach a copy of the declaration of domestic partnership registered prior to April 1, 2018, with the office of the Register of Deeds in the county of residence. I certify that my domestic partner and I satisfy all of the following criteria:
- Each of us is at least eighteen (18) years old and capable of consenting to the domestic partnership;
 - Neither are married or in a domestic partnership with another individual;
 - We share a common residence;
 - We are not nearer kin than second cousins; and,
 - We are members of the same sex.
- Unregistered – Attach a copy of the affidavit filed before September 23, 2017, as an unregistered domestic partner with the Department of Employee Trust Funds. I certify that my domestic partner and I satisfy all of the following criteria:
- Each of us is at least eighteen (18) years old and competent to enter into a contract;
 - Neither are married or in a domestic partnership with another individual;
 - We share a common residence;
 - We are not related by blood in any way that would prohibit marriage under Wisconsin law;
 - We consider ourselves to be members of each other's immediate family; and,
 - We agree to be responsible for each other's basic living expenses.

I certify the information provided above to be a true and accurate description of my relationship with the individual named as my domestic partner. I understand that I must immediately notify the Human Resources Manager should this domestic partnership dissolve any time after I submit this certification and that my failure to do so may result in discipline, up to and including termination.

Employee's Signature

Date

Please submit this Form with the FMLA Leave of Absence Request Form to your supervisor/department.