



CITY OF SAINT PAUL REQUEST FOR FAMILY/MEDICAL LEAVE
(More than Three (3) work days/shifts)

Employee Name: \_\_\_\_\_ Employee ID #: \_\_\_\_\_

Division/Department: \_\_\_\_\_ Shift: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Date of Request: \_\_\_\_\_ (Expectation: 30-day notice when foreseeable)

I am requesting a Leave of Absence for the following reasons (check one):

- A. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position.
B. In order to care for a family member if such family member has a serious health condition. Please circle one: CHILD SPOUSE PARENT OTHER:
C. The birth of a child and in order to care for such child, or the placement of a child for adoption or foster care.
D. A qualifying exigency arising out of the fact that a family member is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
E. You are unable to work (or telework) because you need to care for a son or daughter under 18 years of age whose school or place of care has been closed, or your child care provider is unavailable due to an public health emergency.

Method and Dates of Leave Requested:

Leave shall begin on the first day the employee is approved to be absent from work, paid or unpaid.

A. Consecutive Leave
Approximate Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

B. Intermittent or Reduced Schedule (Please specify schedule below): \_\_\_\_\_

Request for Compensation during approved leave:

- Accrued Sick leave\* Dates: \_\_\_\_\_
• Use up all Sick Leave \_\_\_\_\_ or save 5 days of Sick Leave \_\_\_\_\_
Accrued Vacation\* Dates: \_\_\_\_\_
• Use up all accrued vacation \_\_\_\_\_ or save 5 days of vacation \_\_\_\_\_
Comp Time Dates: \_\_\_\_\_
Paid Parental Leave\* Start Date: \_\_\_\_\_ (See City's Paid Parental Leave Policy)
Short Term Disability? Yes \_\_\_\_\_ No \_\_\_\_\_
• If using short term disability, it is the employee's responsibility to contact The Standard and to communicate with your supervisor and payroll regarding the number of hours of Short term disability you have been approved for. The Standard is at 1-800-378-2395.

Please return this request form to your supervisor and Human Resources Representative. Extended leave requests will be reviewed and responded to based upon applicable policies and laws. Please contact your supervisor and / or Human Resources, if you have any questions on a request for extended leave. FMLA policies- for more information on FMLA.

I understand the City may require I use all accrued paid leave down to 5 days prior to granting unpaid FMLA

\*Payment of accrued and or available leave compensation may be delayed or denied if required medical documentation is not received by Central HR by the due date on your FMLA designation letter.

Employee Signature

Date

**Please return this form to: Human Resources – Benefits ATTN: Rachel Larson  
25 West 4<sup>th</sup> Street, 200 City Hall Annex, 3<sup>rd</sup> Floor, Saint Paul MN 55102**



**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider’s name and business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax:( \_\_\_\_\_ ) \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?  
\_\_\_ No \_\_\_ Yes. If so, dates of admission: \_\_\_\_\_

Date(s) you treated the patient for condition: \_\_\_\_\_

Was medication, other than over-the-counter medication, prescribed? \_\_\_ No \_\_\_ Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? \_\_\_ No \_\_\_ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  
\_\_\_ No \_\_\_ Yes. If so, state the nature of such treatments and expected duration of treatment:

\_\_\_\_\_  
\_\_\_\_\_

2. Is the medical condition pregnancy? \_\_\_ No \_\_\_ Yes. If so, expected delivery date: \_\_\_\_\_

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such as medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART B: AMOUNT OF CARE NEEDED:** When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?  No  Yes.

Estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

During this time, will the patient need care?  No  Yes.

Explain the care needed by the patient and why such care is medically necessary:

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5. Will the patient require follow-up treatments, including any time for recovery?  No  Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

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Explain the care needed by the patient, and why such care is medically necessary: \_\_\_\_\_

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6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?  No  Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

Explain the care needed by the patient, and why such care is medically necessary:

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7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? \_\_\_ No \_\_\_ Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_ times per \_\_\_ week(s) \_\_\_ month(s)

Duration: \_\_\_ hours or \_\_\_ day(s) per episode

Does the patient need care during these flare-ups? \_\_\_ No \_\_\_ Yes.

Explain the care needed by the patient, and why such care is medically necessary: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Health Care Provider**

\_\_\_\_\_  
**Date**

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**