SAINT PAUL
MINNESOTA

CITY OF SAINT PAUL REQUEST FOR EMPLOYEE/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.

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 ☐

NOTE: Non-birthing parents may not use sick leave unless providing care to a birthing parent and/or newborn due to a qualifying health condition. A doctor's note is required to verify a qualifying health condition.

☐ 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 forward this form to your Department's HR Liaison and Payroll Specialist

Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.
RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered veteran with a serious illness or injury. The FMLA allows an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I – EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the health care provider for the information necessary for a complete and sufficient medical certification. **Recertifications are not allowed for FMLA leave to care for a covered servicemember. Where medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents.** In lieu of this form or your own certification form, you **must** accept as sufficient certification of the veteran's serious injury or illness documentation indicating the veteran's enrollment in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310**.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer Name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) This certification must be returned by: _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE and/or VETERAN

Please complete all Parts in Section II before having the veteran's health care provider complete Section III. The FMLA allows an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for military caregiver leave under the FMLA due to a serious injury or illness of a covered veteran. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. The employer must give an employee **at least 15 calendar days** to return this form to the employer. 29 U.S.C. §§ 2613, 2614(c)(3).

PART A: EMPLOYEE INFORMATION

(1) Name of veteran for whom employee is requesting leave: _____
First *Middle* *Last*

Employee Name: _____

(2) Select your relationship to the veteran. You are the veteran's:

☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for a covered servicemember who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a covered servicemember for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. "Next of kin" is the veteran's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the veteran for purposes of FMLA leave, (2) blood relatives granted legal custody of the veteran, (3) brothers and sisters, (4) grandparents, (5) aunts and uncles, and (6) first cousins.

PART B: VETERAN INFORMATION AND CARE TO BE PROVIDED TO THE VETERAN

(3) The veteran was (☐ honorably / ☐ dishonorably) discharged or released from the Armed Forces, including the National Guard or Reserves. List the date of the veteran's discharge: _____ *(mm/dd/yyyy)*

(4) Please provide the veteran's military branch, rank and unit at the time of discharge: _____

_____

(5) The veteran (☐ is / ☐ is not) receiving medical treatment, recuperation, or therapy for an injury or illness.

(6) Briefly describe the care you will provide to the veteran: *(Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Psychological Comfort ☐ Physical Care ☐ Other: _____

(7) Give your **best estimate** of the amount of FMLA leave needed to provide the care described: _____

_____

(8) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced work schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* I am able to work: _____ *(hours per day)* _____ *(days per week).*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran.

Note: For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a veteran, and is: a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

Employee Name: _____

"Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care provider listed above. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name: *(Print)* _____

Health Care Provider's business address: _____

Type of Practice/Medical Specialty: _____

Telephone: (___) _____ Fax: (___) _____ E-mail: _____

Please select the type of FMLA health care provider you are:

- ☐ DOD health care provider
- ☐ VA health care provider
- ☐ DOD TRICARE network authorized private health care provider
- ☐ DOD non-network TRICARE authorized private health care provider
- ☐ Health care provider as defined in 29 CFR 825.125

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the veteran's condition for which the employee is seeking leave. If you are unable to make certain military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD Recovery Care Coordinator, or an authorized VA representative. 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).

(1) Patient's Name: _____

(2) List the approximate date condition started or will start: _____ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition will last: _____

(4) The veteran's injury or illness: *(Select as appropriate)*

- ☐ Was incurred in the line of duty on active duty
- ☐ Existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty
- ☐ None of the above

The veteran (☐ is / ☐ is not) undergoing medical treatment, recuperation, or therapy for this condition. If yes, briefly describe the medical treatment, recuperation, or therapy: _____

_____

Employee Name: _____

(5) The veteran's medical condition is: *(Select as appropriate)*

- ☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember not able to perform the duties of the servicemember's office, grade, rank, or rating.
- ☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.
- ☐ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.
- ☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.
- ☐ None of the above. *Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.*

Part C: Amount of Leave Needed

For the medical condition checked in Part B, complete all that apply. Some 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 military caregiver leave coverage.

(1) Due to the condition, the veteran will need care for a **continuous period of time**, including any time for treatment and recovery. Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for this period of time.

(2) Due to the condition, it is medically necessary for the veteran to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery _____ *(e.g. 3 days/week)*

(3) Due to the condition, it is medically necessary for the veteran to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the veteran's recovery. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, intermittent care is estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Signature of Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

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, in accordance with 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 15 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 Avenue, NW, Washington, DC 20210.

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