CITY OF SAINT PAUL
REQUEST FOR FAMILY/MEDICAL LEAVE

Employee Name: _____ **Date of Request:** _____

Department/Office: _____ **Employee ID #:** _____

I request a Family/Medical Leave for the following reasons (check one):

_____ A. The birth of a child and in order to care for such child, or the placement of a child for adoption or foster care. Family/Medical Leave shall begin on the first day the employee is absent from work, paid or unpaid.

_____ B. In order to care for an immediate family member if such family member has a serious health condition. **Please circle one:** CHILD SPOUSE PARENT

_____ C. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. Family/Medical Leave shall begin on the first day the employee is absent from work, paid or unpaid.

_____ 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.

Dates of Family/Medical Leave (approximate):

Starting _____ Ending _____

Method of Leave Requested:

_____ A. Consecutive Leave

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

_____

_____

If the duration of my family/medical leave (total of paid and unpaid time) does not exceed 12 weeks, I will be returned to my same or equivalent position. I understand that if my family/medical leave should exceed 12 weeks, I will be returned to my same or similar position, only if available, in accordance with applicable laws. If my same or similar position is not available, I understand that I may be terminated.

I understand that the City may require that I use all accrued paid leave prior to granting unpaid FMLA.

Employee Signature_____ **Date** _____

Please return this form to: **Human Resources - Benefits**
25 West 4th Street
200 City Hall Annex
Saint Paul, MN 55102

MEDICAL CERTIFICATION STATEMENT

Employee's Own Serious Illness

(To be completed and signed by your physician)

Name of employee: _____

Employee's home address: _____

Employee's home phone number: _____

Date condition began: _____

Date condition ended (or is expected to end): _____

Medical facts regarding the condition: _____

_____

_____

_____

_____

Explanation of extent to which employee is unable to perform the functions of his or her job:

_____

_____

_____

Will it be necessary for the employee to work intermittently or to work on less than a full schedule due to this condition? _____

If yes, please state the probable duration: _____

If the condition is a chronic condition or pregnancy, state whether the employee is presently incapacitated and the likely duration and frequency of episodes of incapacity: _____

_____

_____

If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: _____

If the treatments will be provided on an intermittent or part-time basis, provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery, if any: _____

_____

_____

If any of these treatments will be provided by another provider of health services, please state the nature of the treatments: _____

_____

_____

Is the employee unable to perform work of any kind? _____

_____

If unable to perform some work, is the employee unable to perform one or more of the essential functions of the employee's job? _____

_____

If yes, please list the essential functions the employee is unable to perform: _____

_____

_____

_____

If the employee's condition does not limit his or her ability to perform work, is it necessary for the employee to be absent from work for treatment? _____

Health care provider signature: _____

Date: _____ Office Phone: _____

Medical Release:

I authorize the release of any medical information necessary to process the above request:

Patient's signature: _____ Date: _____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.