

### CITY OF SAINT PAUL REQUEST FOR FAMILY/MEDICAL LEAVE

Employee N	Name: Dat	Date of Request:		
Department	t/Office: Em	Employee ID #:		
I request a I	Family/Medical Leave for the following reasons (o	check one):		
A B C D.	The birth of a child and in order to care for such c adoption or foster care. Family/Medical Leave sh is absent from work, paid or unpaid.  In order to care for an immediate family member in health condition. <b>Please circle one:</b> CHIL Employee's own serious health condition that mal functions of his/her position. Family/Medical Leave employee is absent from work, paid or unpaid.	if such family member has a serious LD SPOUSE PARENT kes the employee unable to perform the ave shall begin on the first day the		
	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 Far	mily/Medical Leave (approximate):			
Starting	Ending			
Method of L	Leave Requested:			
A. B.	Consecutive Leave Intermittent or Reduced Schedule (Please specify	schedule below):		
will be return exceed 12 we applicable land I understand	on of my family/medical leave (total of paid and unparted to my same or equivalent position. I understand veeks, I will be returned to my same or similar position aws. If my same or similar position is not available, I define that the City may require that I use all accrued paid	that if my family/medical leave should on, only if available, in accordance with I understand that I may be terminated. leave prior to granting unpaid FMLA.		
Employee Signature Date				
Please retur	rn this form to: Human Resources - Benefits 200 City Hall Annex 25 West 4 <sup>th</sup> Street			

Saint Paul, MN 55102

# Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

## U.S. Department of Labor Wage and Hour Division



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

OMB Control Number: 1235-0003 Expires: 8/31/2021

#### **SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of 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.

and in accordance with 29 C.F.K.	3 1033.9, if the Genetic I	momation	Nonaiscillillation	Act applies.
Employer name and contact:				
SECTION II: For Completion by INSTRUCTIONS to the EMPLO member or his/her medical provide complete, and sufficient medical complete, and sufficient medical complete member with a serious health concretain the benefit of FMLA protect sufficient medical certification may must give you at least 15 calendar. Your name:	DYEE: Please complete er. The FMLA permits a ertification to support a relition. If requested by your cons. 29 U.S.C. §§ 2613 yresult in a denial of your substantial subs	n employer request for lour employe 3, 2614(c)(3 ur FMLA re	to require that you FMLA leave to care er, your response is b). Failure to provide equest. 29 C.F.R. §	submit a timely, e for a covered family required to obtain or de a complete and 825.313. Your employer
First	Middle	I	Last	
Name of family member for whom Relationship of family member to		First	Middle	Last
If family member is your son o				
Describe care you will provide to y	our family member and	estimate le	ave needed to prov	ide care:
Employee Signature Page 1	CONTINUED ON	 Date		Form WH-380-F Revised May 201:

#### 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: ()					
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? NoYes. If so, dates of admission:					
Date(s) you treated the patient for condition:					
Was medication, other than over-the-counter medication, prescribed?NoYes.					
Will the patient need to have treatment visits at least twice per year due to the condition?NoYes					
Was the patient referred to other health care provider(s) for evaluation or treatment ( <u>e.g.</u> , physical therapist)?  NoYes. If so, state the nature of such treatments and expected duration of treatment:					
2. Is the medical condition pregnancy?NoYes. If so, expected delivery date:					
3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):					

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

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

7. Will the condition cause episodic flare-ups period activities?NoYes.	dically preventing the patient from participating in normal daily
	ar knowledge of the medical condition, estimate the frequency of hat the patient may have over the next 6 months (e.g., 1 episode
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 QU	ESTION 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.**