



**CITY OF SAINT PAUL
REQUEST FOR FAMILY/MEDICAL LEAVE
(FOR CARE OF SERVICE MEMBER)**

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

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

I request a Family/Medical Leave because I am a family member of a covered service member with a serious injury or illness.

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 26 weeks, I will be returned to my same or equivalent position. I understand that if my family/medical leave should exceed 26 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
200 City Hall Annex
25 West 4th Street
Saint Paul, MN 55102**