

**REQUEST FOR FAMILY/MEDICAL LEAVE OF ABSENCE
ON AN INTERMITTENT/REDUCED SCHEDULE LEAVE BASIS**

This form is to be completed by the EMPLOYEE requesting a paid or unpaid "intermittent or reduced schedule" leave of absence under provisions of the federal "Family and Medical Leave Act of 1993" and City of St. Louis Administrative Regulation No. 133. This form should be completed and submitted to the Appointing Authority at least thirty (30) days in advance of the beginning of such non-paid leave, except in those cases where the nature of the medical/family emergency precludes such advance notice. Requests for this type of leave must be shown to be "medically necessary." Intermittent Leave is leave taken in blocks of one hour to several days duration at a time over a period of months, normally on an irregular basis. Reduced Schedule Leave is regularly occurring leave which, in effect, reduces an employee's regular workday or workweek hours over a period of months.

1. EMPLOYEE NAME: _____ 2. JOB TITLE: _____

3. DEPARTMENT: _____ 4. DIVISION/SECTION: _____

5. TYPE OF LEAVE REQUESTED: Intermittent Reduced Schedule

6. SPAN OF LEAVE PERIOD: From _____ To _____

7. ANTICIPATED LEAVE SCHEDULE: _____

8. PAID LEAVE REQUESTED: _____

9. I request Family/Medical Leave for the following reason:

For a personal serious health condition which renders me unable to perform the functions of my job

To care for the following qualifying relative with a serious health condition (check one):

Legal spouse

Parent (includes natural or adoptive parent, stepparent, legal

Person with "in loco parentis" status to the employee when the

Son or Daughter (includes natural, adoptive or foster child, or incapable of self-care because of a mental or physical disability)

Child for whom employee has status as "in loco parentis"

10. A. If the employee will be providing care for a qualifying relative, please print the full name of the relative below:

B. Will the "serious medical condition" require hospitalization of

Yes No

I certify that the information provided is correct to the best of my knowledge.

Employee Signature _____ Date _____

APPOINTING AUTHORITY RESPONSE TO
REQUEST FOR FAMILY/MEDICAL LEAVE OF ABSENCE

This form is to be completed by the APPOINTING AUTHORITY within five (5) business days of receipt. Determinations reached must comply with the provisions of the City of St. Louis Administrative Regulation No. 133, "Family/Medical Leave." This original form should be submitted to the Department of Personnel, Employee Relations Section, with the "Employee Status Form" (if necessary) placing the employee on leave and any medical or supporting documentation required, at least thirty (30) days in advance when foreseeable of the date leave begins; a copy of the completed form should be given to the employee.

1. APPOINTING AUTHORITY RESPONSE:

- Your request is approved as submitted, subject to providing the supporting documents (if any) checked under Item 4 below.
- Your request is approved under revised terms as outlined under Item 2 below,
- The terms and conditions of your request were reviewed with the Department of Personnel. Your request is denied for the reasons outlined under Item 3 below.

2. REVISED TERMS OF LEAVE (if any): (usually limited to delay of the start of leave due to employee's failure to provide either thirty (30) days advance notice in foreseeable situations, or required documentation within fifteen (15) days of request by appointing authority; can be a mutually agreed upon revision between the employee and the appointing authority, such as paid leave granted)

3. REASON FOR DENIAL: (if applicable)

- Employee is ineligible for family/medical leave
- Reason for leave outlined on reverse side of this form does not qualify for family/medical leave
- Failure to supply requested documentation, or documentation submitted does not support eligibility for family/medical leave
- Other: _____

4. NOTICE TO EMPLOYEE OF SUPPORTING DOCUMENTATION REQUIREMENTS:

- Completion of "Certification of Physician or Practitioner" form (employee should be provided with a copy of this "Certification" form) to document medical condition(s) supporting leave request
- Proof of the expected date of birth or placement of a child
- Proof of an "immediate family member's" qualifying relationship to the employee requesting family/medical leave
- "Fitness for duty" statement from a physician/practitioner (required before the employee will be allowed to return from a leave of absence due to a personal serious health condition)
- Other: _____

Appointing Authority Signature _____ Date _____

Date copy was forwarded to employee: _____