REQUEST FOR INTERMITTENT/REDUCED SCHEDULE
MILITARY FAMILY/MEDICAL LEAVE OF ABSENCE
FOR CARE OF SERVICEMEMBER

This form is to be completed by the EMPLOYEE requesting a paid or unpaid leave of absence under provisions of the federal "Family/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 30 days in advance of the beginning of such leave, except in those cases where the nature of the medical emergency precludes such advance notice.

1. **EMPLOYEE NAME:** _____

2. **JOB TITLE:** _____

3. **TYPE OF Leave Requested:** _____**Intermittent** _____**Reduced Schedule**

4. **DEPARTMENT:** _____ **5.DIVISION/SECTION:** _____

6. **REQUESTED LEAVE PERIOD: From** _____ **To** _____

7. **PAID LEAVE REQUESTED:** _____

8. **ANTICIPATED LEAVE SCHEDULE:** _____

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

   ____ **FOR CARE OF SERVICE MEMBER**

10. **To care for the following qualifying relative with a serious health condition resulting from military service (check one):**

    ___ **Legal spouse or Domestic Partner**

    ___ **Parent (includes natural or adoptive parent, stepparent, legal guardian; does not include in-laws)**

    ___ **Person with "in loco parentis" status to the employee when the employee was a child**

    ___ **Son or Daughter (includes natural, adoptive or foster child, or stepchild)**

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

    or ___**Next of Kin (give specifics)** _____

11. **Please complete the following:**

    A. **Please print the full name of the relative below:**

    _____

    B. **Will the "serious medical condition" require hospitalization of the qualifying relative?**

    ___ **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 MILITARY FAMILY/MEDICAL LEAVE OF ABSENCE FOR CARE OF SERVICEMEMBER

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 appropriate) placing the employee on leave, and any medical or supporting documentation required, at least thirty (30) days in advance 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, subject to providing the supporting documents (if any) 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 30 days advance notice in foreseeable situations or required documentation within 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 (to document medical condition(s) supporting leave request)**

___ **Proof of an "immediate family member's" qualifying relationship to the employee requesting family/medical leave**

___ **Other:** _____

Appointing Authority Signature _____ **Date** _____

Date copy was forwarded to employee: _____

Dept. #123 Revised 12-09