MINNESOTA STATE

Employee Request for Leave or Extension of Leave Under FMLA and/or MPL

This form is required to request Family Medical Leave Act (FMLA) / Minnesota Paid Leave (MPL)/ Paid Parental Leave (PPL).
https://mn.gov/mmb-stat/policies/1409-fmlapolicy.pdf
https://mn.gov/mmb-stat/policies/1435-paid-parental-leave-updated.pdf
https://mn.gov/mmb-stat/policies/1450-minnesota-paid-leave.pdf
For additional information regarding Minnesota Paid Leave (MPL) go to the DEED website: https://paidleave.mn.gov/

Submit your request at least 30 days in advance of the need for leave when the leave is foreseeable. If your need for leave is not foreseeable, please submit this form as early as possible. The employer reserves the right to deny or postpone leave for failure to give appropriate notice when such a denial/postponement would be permitted under federal or state law.

Employee

Name		**Employee ID**
Department		**Supervisor**
Phone Number Work: Home:		**Email Address** Work: Home:
Is this request for Leave: ☐An initial request ☐An extension/modification request		**If the request is to extend or modify the initial request, please explain here.**
Leave will be taken as: ☐Continuous leave ☐Intermittent leave ☐Reduced schedule	**Anticipated leave begin date**	**Anticipated leave end date**

What is your reason for Leave:

☐A serious health condition that makes the employee unable to perform one or more of the essential functions of an employee's job.
☐Bonding Leave (time spent by an employee who is the biological, adoptive or foster parent to care for a biological, adopted, or foster child in conjunction with the child's birth, adoption, or placement).
☐Safety Leave
☐To care for the employee's family member with a serious health condition.
☐Because of a qualifying exigency arising out of the fact that the employee's family member is a military member on covered active duty (or has been notified of an impending call or order to covered active duty status).
☐Need to care for an immediate family member* who is also a covered service member who has become seriously ill or injured while on active duty.

Check all types of accrued paid leave to be used concurrently with FMLA and/or MPL:

☐Sick
☐Vacation ☐Other (please select below) ☐None (I do not plan to use any paid leave)

Select all other types of paid leave programs you plan to use to supplement your leave:

☐MPL (benefit payments/wage replacement)
☐Short-term disability
☐Paid Parental Leave

Is your spouse employed by the State of Minnesota? ☐Yes ☐No	**If yes, are they taking or have they already taken FMLA for the same reason?** ☐Yes ☐No

Spouse's Name:	**Please provide the number of days/hours your spouse has used or requested:**

I certify that my statements and documentation in this request are accurate and truthful.

☐ Yes, my statements and documentation are accurate.

☐ No, I cannot certify that my statements and documentation are accurate.

Notice of Intent to Collect Private Data

Your agency is requesting that you provide the private data listed below because you are requesting leave that may qualify for protection under the Family and Medical Leave Act ("FMLA"), Minnesota Paid Leave ("MPL"), other state or federal law, policy, collective bargaining agreement, or compensation plan. This notice explains why the private data is being requested, how the data will be used, who has access to the data, and what may happen if you do or do not provide the requested data.

Data Requested You are being asked to provide the following data:

- The anticipated timing and duration of your requested leave of absence;
- Information sufficient to determine whether your need for leave qualifies for protection under the FMLA, MPL, other state or federal law, policy, collective bargaining agreement, or compensation plan;
- Information relating to a qualifying family member, as applicable;
- Information that may be requested in a Certification of Health Care Provider; Certification of Qualifying Exigency; Certification for Serious Injury or Illness of a Current Servicemember; Certification for Serious Injury or Illness of a Veteran; or other documentation sufficient to establish qualification for a leave of absence.

Use of Data

The data listed above will be used to determine whether you qualify for and, if so, to administer a leave of absence, including under the FMLA, MPL, and/or other leaves of absences as provided for under state or federal law, policy, collective bargaining agreement, or compensation plan.

Access to Data

The data that you provide may be shared with:

- Human Resources
- Exclusive representatives
- Minnesota Management and Budget
- ADA coordinator/staff
- Workers' compensation personnel
- Authorized personnel whose jobs reasonably require access
- MPL personnel within the Department of Employment and Economic Development ("DEED")
- Any other person or entity authorized by federal or state law to access the data, including but not limited to the Office of the Legislative Auditor, Office of the State Auditor, law enforcement, or others as authorized by a court order.

Right of Refusal

You are not required to provide any of the requested data. If you do not provide the requested data, leave benefits may be denied or delayed for you. It is your responsibility to provide information and documentation sufficient to establish qualification for a leave of absence. By signing this form, you acknowledge that you have received and understand the information above.

☐ Yes

☐ No, I do not consent

_____ _____

Signature of Employee Date