Employee Request for Sick Leave Form
City of Minneapolis Human Resources Department

When completing this form please type or print legibly in ink. This form should be completed when the:

1. Employee is requesting more than three (3) to five (5) consecutive days of sick leave in accordance with Civil Service Rules or their labor agreement whichever applies; or
2. Employee has used more than 12 days of unverified sick leave in one calendar year; or
3. Manager or supervisor requires medical verification for sick leave requests.

TO BE COMPLETED BY EMPLOYEE		
Name (Last, First, MI)	Employee Number	Department
Request for ☐ Myself ☐ Spouse/Domestic Partner ☐ Child	Home Telephone Number	
Dates: From _____ Through_____	Sick Leave Requested _____ Days _____ Hours	
Reason for Request		
Employee Signature Date	Work Location	

TO BE COMPLETED BY DEPARTMENT	
I hereby certify that the above employee has been off duty for the period specified above and has complied with the requirements governing the use of sick leave by employees.	
Supervisor's Signature Date	Department Head Signature Date

TO BE COMPLETED BY PHYSICIAN	
Patient Name	Patient's Job Title
Physician's Name (Please Print)	Physician's Address
Date of first exam/consult for this illness	Date most recent exam/consult for this illness
Diagnosis	

WORK STATUS – ABILITY TO RETURN TO WORK	
Can the employee return to work without restrictions? ☐ Yes ☐ No	
Can employee return to work in a light-duty or limited-duty capacity? ☐ Yes ☐ No	
What restrictions, if any?	
What is the probable duration of the restrictions?	
Physician's Signature Date	**Retention:** Please place a copy of the completed form in the employee's Department Medical file.

Civil Service Commission Rules - 15.11, 15.14, 15.15, 14.04 (A),