Government of the Virgin Islands of the United States

DEPARTMENT OF HUMAN SERVICES

Office of Human Resources, Labor Relations & Payroll

New ☐ **Extension** ☐

EMPLOYEE REQUEST FOR FAMILY MEDICAL LEAVE

Name: _____ Division: _____

Current Address: _____

Phone: _____ Email: _____

Start of Anticipated Leave: _____

Expected Return to Work Date: _____

Reason for Leave (Briefly Explain): _____

Self ☐ Family ☐ |Hours Requested: _____ Sick Leave Balance: _____ Annual Leave Balance: _____
**If required*

Will donated leave be used? Yes ☐ No ☐ If yes, how many hours? _____

NOTE: An employee requesting leave for the employee's serious health condition or the serious health condition of the employee's spouse, child, or parent, must submit a verifying medical certification from a physician within 15 days of application for leave.

I hereby authorize a health care provider or designee representing [The Government of the United States Virgin Islands] to contact my physician to verify the reason for my requested Family Medical Leave.

I understand that failure to return to work at the end of my leave period may be treated as resignation / job abandonment unless an extension has been agreed upon and approved in writing by the Department of Human Services.

_____ _____
Employee Signature Date

Employee should return form to HR with supporting documents

APPROVED BY:

_____ _____
Supervisor Date

_____ _____
Administrator Date

_____ _____
Deputy Commissioner, Human Resources & Labor Relations Date

_____ _____
Commissioner Date