GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES

Department of Human Services

Office of Human Resources
Personnel and Labor Relations

EMPLOYEE FMLA REQUEST

FAMILY MEDICAL LEAVE
APPLICATION FOR FAMILY MEDICAL LEAVE

Name: _____ Division: _____

Current Address: _____

Start of Anticipated Leave: _____

Expected Date of Return to Work: _____

Reason for Leave (Explain):_____

_____

NOTE: Am employee requesting leave for the employee's serious health condition of 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 a 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

APPROVED BY:

_____ _____
Supervisor Date

_____ _____
Administrator Date

_____ _____
Deputy Commissioner, Human Resources & Labor Relations Date

_____ _____
Commissioner Date