



Department of Human Services

Office of Human Resources
Personnel and Labor Relations

EMPLOYEE FAMILY 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: 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 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