



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