STATE OF WEST VIRGINIA
APPLICATION FOR LEAVE WITH PAY

NAME:

WORK UNIT/SECTION: | **DIVISION:**

I AM MAKING APPLICATION FOR THE FOLLOWING LEAVE:

_____ Hours Annual _____ Hours Sick

_____ Hours Military _____ Hours Sick (Imm. Family)

_____ Hours Witness/Jury Service _____ Hours Sick (Death in Imm. Family)

PERIOD OF LEAVE:

FROM Date: _____ _____ A.M. P.M.

TO Date: _____ _____ A.M. P.M.

EMPLOYEE SIGNATURE: | **APPLICATION DATE:**

❑ Approved **IMMEDIATE SUPERVISOR SIGNATURE:**

❑ Disapproved **DATE:**

❑ Approved **AGENCY-AUTHORIZED SIGNATURE:**

❑ Disapproved **DATE:**

REMARKS (In addition to any pertinent remarks, please also use this space to note relationship if using sick leave for a family member's illness or death):

- A Physician's/Practitioner's Statement (DOP-L3) is required after 3 consecutive working days of sick leave.
- Sick leave used for immediate family members is limited to 40 hours per calendar year.
- A maximum of 3 days of sick leave may be used for each occurrence of a death in the employee's immediate family.
- When witness/jury service leave or military leave is used, you must submit copies of the appropriate subpoena, summons, or military orders, according to Division of Personnel rules and policies.

FORM DOP-L1 **02/08/96**

STATE OF WEST VIRGINIA
APPLICATION FOR LEAVE WITH PAY

NAME:

WORK UNIT/SECTION: | **DIVISION:**

I AM MAKING APPLICATION FOR THE FOLLOWING LEAVE:

_____ Hours Annual _____ Hours Sick

_____ Hours Military _____ Hours Sick (Imm. Family)

_____ Hours Witness/Jury Service _____ Hours Sick (Death in Imm. Family)

PERIOD OF LEAVE:

FROM Date: _____ _____ A.M. P.M.

TO Date: _____ _____ A.M. P.M.

EMPLOYEE SIGNATURE: | **APPLICATION DATE:**

❑ Approved **IMMEDIATE SUPERVISOR SIGNATURE:**

❑ Disapproved **DATE:**

❑ Approved **AGENCY-AUTHORIZED SIGNATURE:**

❑ Disapproved **DATE:**

REMARKS (In addition to any pertinent remarks, please also use this space to note relationship if using sick leave for a family member's illness or death):

- A Physician's/Practitioner's Statement (DOP-L3) is required after 3 consecutive working days of sick leave.
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FORM DOP-L1 **02/08/96**

STATE OF WEST VIRGINIA
APPLICATION FOR LEAVE OF ABSENCE WITHOUT PAY

NAME:

WORK UNIT/SECTION: | **DIVISION:**

I AM MAKING APPLICATION FOR THE FOLLOWING LEAVE OF ABSENCE:

_____ Personal Without Pay _____ Educational Without Pay
_____ Medical Without Pay _____ Military Without Pay

PERIOD OF LEAVE:

FROM Date: _____ _____ A.M. P.M.

TO Date: _____ _____ A.M. P.M.

REASON (a separate letter may be attached if necessary):

I understand that if I do not return at the expiration of an approved leave of absence, my employment may be terminated, unless an extension has been approved in advance.

EMPLOYEE SIGNATURE: **APPLICATION DATE:**

❑ Approved **IMMEDIATE SUPERVISOR SIGNATURE:**

❑ Disapproved **DATE:**

❑ Approved **AGENCY-AUTHORIZED SIGNATURE:**

❑ Disapproved **DATE:**

- A Physician's/Practitioner's Statement (DOP-L3) must be attached when requesting a **medical** leave of absence without pay.
- An **official** order from the appropriate military officer must be attached when requesting a **military** leave of absence without pay.
- **Do not use this form for requesting a leave of absence without pay under the Federal Family Medical Leave (FMLA) or State Parental Leave Acts.** Instead, use Forms DOP-L4 and DOP-L5.

FORM DOP-L2 **02/08/96**

STATE OF WEST VIRGINIA
APPLICATION FOR LEAVE OF ABSENCE WITHOUT PAY

NAME:

WORK UNIT/SECTION: | **DIVISION:**

I AM MAKING APPLICATION FOR THE FOLLOWING LEAVE OF ABSENCE:

_____ Personal Without Pay _____ Educational Without Pay
_____ Medical Without Pay _____ Military Without Pay

PERIOD OF LEAVE:

FROM Date: _____ _____ A.M. P.M.

TO Date: _____ _____ A.M. P.M.

REASON (a separate letter may be attached if necessary):

I understand that if I do not return at the expiration of an approved leave of absence, my employment may be terminated, unless an extension has been approved in advance.

EMPLOYEE SIGNATURE: **APPLICATION DATE:**

❑ Approved **IMMEDIATE SUPERVISOR SIGNATURE:**

❑ Disapproved **DATE:**

❑ Approved **AGENCY-AUTHORIZED SIGNATURE:**

❑ Disapproved **DATE:**

- A Physician's/Practitioner's Statement (DOP-L3) must be attached when requesting a **medical** leave of absence without pay.
- An **official** order from the appropriate military officer must be attached when requesting a **military** leave of absence without pay.
- **Do not use this form for requesting a leave of absence without pay under the Federal Family Medical Leave (FMLA) or State Parental Leave Acts.** Instead, use Forms DOP-L4 and DOP-L5.

FORM DOP-L2 **02/08/96**

STATE OF WEST VIRGINIA
PHYSICIAN'S/PRACTITIONER'S STATEMENT

PATIENT'S NAME:	EXAM DATE:

PATIENT WAS:

❑ Under my professional care FROM _____ TO _____

❑ Hospitalized FROM _____ TO _____

PERIOD OF INCAPACITY:

FROM **TO**

Date: _____ Date: _____

Patient was or may be able to resume **full duty employment,** with no restrictions in work activities, on _____.

If unable to presently return to full duty employment, can the patient return to less than full duty? ❑ YES ❑ NO

If yes, what is the period of partial incapacity?

FROM _____ TO _____

LIMITATIONS/RESTRICTIONS:

Describe in detail any limitations or restrictions on the ability of the employee to work. List any assistive devices or equipment or any accommodation the employee requires to perform his/her job.

Will this disability permanently prevent the employee from performing his/her duties?

❑ YES ❑ NO

PHYSICIAN/PRACTITIONER INFORMATION:

NAME: TELEPHONE:

ADDRESS:

SIGNATURE:

NOTE: This form is to be used in all situations which require a Physician's/Practitioner's Statement (DOP-L3) except when requesting a leave with or without pay under the State Parental Leave or federal Family/Medical Leave Acts. When requesting leave under these Acts, use the Physician's/Practitioner's Certification (DOP-L4).

STATE OF WEST VIRGINIA
PHYSICIAN'S/PRACTITIONER'S STATEMENT

PATIENT'S NAME:	EXAM DATE:

PATIENT WAS:

❑ Under my professional care FROM _____ TO _____

❑ Hospitalized FROM _____ TO _____

PERIOD OF INCAPACITY:

FROM **TO**

Date: _____ Date: _____

Patient was or may be able to resume **full duty employment,** with no restrictions in work activities, on _____.

If unable to presently return to full duty employment, can the patient return to less than full duty? ❑ YES ❑ NO

If yes, what is the period of partial incapacity?

FROM _____ TO _____

LIMITATIONS/RESTRICTIONS:

Describe in detail any limitations or restrictions on the ability of the employee to work. List any assistive devices or equipment or any accommodation the employee requires to perform his/her job.

Will this disability permanently prevent the employee from performing his/her duties?

❑ YES ❑ NO

PHYSICIAN/PRACTITIONER INFORMATION:

NAME: TELEPHONE:

ADDRESS:

SIGNATURE:

NOTE: This form is to be used in all situations which require a Physician's/Practitioner's Statement (DOP-L3) except when requesting a leave with or without pay under the State Parental Leave or federal Family/Medical Leave Acts. When requesting leave under these Acts, use the Physician's/Practitioner's Certification (DOP-L4).

FORM DOP-L3 **02/08/96**

STATE OF WEST VIRGINIA
APPLICATION FOR
STATE PARENTAL or FEDERAL FAMILY LEAVE

EMPLOYEE NAME:	WORK AND HOME TELEPHONE NUMBERS:
EMPLOYEE ADDRESS (Street Address, City, State, and Zip Code)	
WORK UNIT/SECTION:	DIVISION:

I AM MAKING APPLICATION FOR PARENTAL/FAMILY LEAVE WITHOUT PAY FOR THE FOLLOWING REASON:

❑ Birth of a Child
❑ Adoption/Foster Child Placement
❑ Illness of Family Member
Specify Member: _____

PERIOD OF LEAVE:				TO BE TAKEN:
FROM	Date: _____	_____	A.M. P.M.	❑ CONTINUOUSLY
TO	Date: _____	_____	A.M. P.M.	❑ INTERMITTENTLY*

EMPLOYEE SIGNATURE:	APPLICATION DATE:

❑ Approved ❑ Disapproved	IMMEDIATE SUPERVISOR SIGNATURE: DATE:	❑ Approved ❑ Disapproved	AGENCY-AUTHORIZED SIGNATURE: DATE:

* **IF LEAVE WITHOUT PAY IS TO BE TAKEN INTERMITTENTLY, PLEASE SPECIFY DATES AND TIMES BELOW:**

NOTE: **THE FEDERAL FAMILY MEDICAL LEAVE ACT (FMLA)** provides for 12 weeks of paid and/or unpaid leave for an employee's own serious illness. Since Section 15.08(c) of the Division of Personnel's *Administrative Rule* provides a more generous unpaid medical leave benefit of up to 6 months, the State benefit fulfills the entitlement provisions of federal law.

An employee who requests an unpaid leave of absence for his or her own serious illness/injury should complete an Application for Leave of Absence Without Pay (Form DOP-L2).

STATE OF WEST VIRGINIA
PHYSICIAN'S/PRACTITIONER'S CERTIFICATION
STATE PARENTAL or FEDERAL FAMILY LEAVE

PATIENT'S NAME:	LAST EXAMINATION DATE:

1. Does illness, injury, or condition qualify as a "serious health condition" under the Family Medical Leave Act (see definition list below). ❑ YES ❑ NO

2. Mark the applicable category: ❑ Hospital Care ❑ Permanent/Long-Term Cond. ❑ Pregnancy
   ❑ Multiple Treatments ❑ Absences Plus Treatments ❑ Chronic Cond.

3. Does the patient require assistance or care? ❑ YES ❑ NO

   If YES, what is the probable duration:

   FROM: Date: _____ **TO:** Date: _____

4. On what basis does the patient require assistance? ❑ CONTINUOUSLY ❑ INTERMITTENTLY

HEALTH CARE PROVIDER SIGNATURE:	DATE:
ADDRESS:	**TELEPHONE: ( )**

A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. **HOSPITAL CARE:** Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with, or consequent to, such inpatient care.

2. **PERMANENT/LONG-TERM CONDITIONS REQUIRING SUPERVISION:** A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's Disease, a severe stroke, or the terminal stages of a disease.

3. **MULTIPLE TREATMENTS (NON-CHRONIC CONDITIONS):** Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity for more than 3 consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

4. **ABSENCES PLUS TREATMENT:** A period of incapacity of more than 3 consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

   A. Treatment 2 or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider, or

   B. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of a health care provider.

5. **CHRONIC CONDITIONS REQUIRING TREATMENTS:** A chronic condition which:

   A. Requires periodic visits for treatment by a health care provide, or by a nurse or physician's assistant under direct supervision of a health care provider;

   B. Continues over an extended period of time (including recurring episodes of a single, underlying condition), and

   C. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

6. **PREGNANCY:** Any period of incapacity due to pregnancy, or for prenatal care.