GOVERNMENT OF THE
UNITED STATES VIRGIN ISLANDS

REQUEST FOR FAMILY/MEDICAL LEAVE

PART I: TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)

1. Name of employee: _____
(first name middle initial last name)

2. Social Security Number: _____

3. Department: _____

4. Employee Number: _____

5. Position Title: _____

6. Employment Date: _____

7. District: _____

8. Total F&M Leave taken within the Calendar Year to Date:_____

9. Reason for requested leave.

a. ☐ Birth of a child
b. ☐ Placement of a child for adoption or foster care
c. ☐ Care for a child within a 12 month period from birth or placement
d. ☐ Care for an immediate family member who has a serious health condition
e. ☐ My own serious health condition

If 9 (c) or (d) apply, please state name and address of immediate family member: _____

_____

10. Date on which you wish to commence leave: _____

11. Date of anticipated return to work: _____

12. Are you requesting leave on an intermittent or reduced leave schedule?
☐ Yes ☐ No

13. If "yes" please give schedule of when you will be unavailable for work (Attach separate sheet if necessary).

I agree to take F & M LEAVE UNDER THE FOLLOWING paid and unpaid leave allocations:

☐ PERIOD OF UNPAID LEAVE FROM _____ TO _____ TOTAL NO. OF HOURS _____

☐ PERIOD OF PAID LEAVE FROM _____ TO _____ TOTAL NO. OF HOURS _____ **(CHECK ONE) SOURCE:** ☐ SICK ☐ ANNUAL

Employees seeking leave because of reasons 9 (c) (d) and/or 8(e) above, must complete the attached Medical Certification Form and return it within 30 days, or as soon as practicable. I understand that my leave may be delayed until I provide a completed Medical Certification Form. I understand that the GVI may require further medical certification during the course of the leave, as deemed appropriate, for the treatment that is scheduled during work hours for serious medical conditions and that I will provide accurate and timely information related to a request for continuation of modification(s) to and return from leave.

Employees seeking to return to work after a leave because of their own serious illness (reason 9 (e)), also must provide certification of their fitness to return to work. I understand that I may not be permitted to resume my position at GVI, until I provide certification of my fitness to return to work.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. Should I elect to discontinue coverage, I further understand that I will not be eligible to re-enroll without proof that I have been enrolled in another benefits plan during the period of the leave. I will, however, be able to enroll in benefits during the next open enrollment. I also agree that if I fail to return to work at the end of the leave period, I will reimburse GVI for the cost of health benefits provided by GVI during my leave, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate healthcare provider stating that I am unable to perform the functions of my position on the date that my leave expired or that I am needed to care for an immediate family member because he/she has a serious health condition on the date that my leave expired.

Signature of employee: _____ Date: _____

Please return your Certificate of Health Care Provider and this form to your Departmental Personnel Officer for further processing.

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