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.

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.

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:

FROM Date: ____________________ __________ A.M. P.M.

TO Date: ____________________ __________ A.M. P.M.

TO BE TAKEN:

❏ CONTINUOUSLY
❏ 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 ❑ Multiple Treatments ❑ Permanent/Long-Term Cond. ❑ Absences Plus Treatments ❑ Pregnancy ❑ 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.