Office of
The Governor

GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES

DIVISION OF PERSONNEL

3438 Kronprindsens Gade, GERS Building, 3rd Floor, St. Thomas, V.I. 00802-5712 (340) 774-8588 FAX (340) 714-5040
3009 Orange Grove Shopping Center, Bays # 6, 7, 8, Christiansted, St. Croix, V.I. 00820 (340) 773-0341 FAX (340) 773-5669

"Doing the People's Business"

Milton E. Potter, SHRM-SCP, MS, IPMA-CP
Director

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Request for Donated Leave

NOTE: This document is CONFIDENTIAL

Part I - To be completed by employee requesting donated leave

Name (Last, First, MI) _____ Employee # _____ Date of Birth _____

Mailing Address (Street, City, State, Zip) _____

Agency (Name and Location) _____ Date of Hire _____ Work Telephone # _____

Alternative Telephone # _____

Illness* of: Employee ☐ Family Member of Employee ☐ (Check one box)

Family Member's Name: _____ Relationship to Employee: _____

Family Member's Present Address: _____

How long has the Family Member been a resident at the present address? _____

Date of Accident/ beginning of Illness _____ Date Disability began _____ Date Returned to Work _____

Briefly describe nature of illness/injury _____

Name of treating physician _____ Physician's address _____ Physician's Telephone # _____ Treatment Date _____

Date all sick leave exhausted: _____ Date all annual leave exhausted: _____

Describe any other income you are receiving or are eligible to receive as a result of your disability.
(Examples: Social Security, Worker's Compensation, Disability Insurance, Pensions, etc.) _____

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital, medical institution, pharmacy, governmental agency, or my present employer having information concerning me, to release said information to the Government of the Virgin Islands or its designated representative to be used for determination of my eligibility for Donated Leave. This authorization shall be valid from the date signed through the duration of this claim.

Employee Signature _____ Date _____

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Part II – To be completed by the employee's agency personnel/payroll office

The above-named employee has:

- used, or will use, all accrued sick leave on _____
- used, or will use, all of his/her accrued annual leave on _____
- has been employed by the Government for (1) year as of _____
- last worked on _____
- Current sick leave balance _____
- Current annual leave balance _____
- Base Pay _____

(NOTE: For illness* or injury of a family member, employee must have used all of his/her sick and annual leave).

I hereby certify that (1) this applicant has been an officer or employee of this Government for at least 1 year and (2) has used all of his/her sick time and annual leave (for illness/injury of family member – has used all of his/her sick time and all of his/her annual leave).

_____ _____
HR/Payroll Officer Signature Date

Part III – To be completed by the Donated Leave Program Committee

We have reviewed the donated leave request to determine if the employee has met all criteria for the Donated Leave Program.

☐ Med. Cert. Rec'd. _____ ☐ Donor Form(s) Rec'd. _____ ☐ Date Pkg. Rec'd. _____
Date Date Date

We recommend: ☐ Denial ☐ Approval granted through _____. For applicant to be eligible to receive Donated Leave beyond the above date, applicant must submit physician's certification certifying continued disability/illness.

Based upon amount of donated leave hours submitted on behalf of the applicant to the Government of Virgin Islands Donated Leave Program, we further recommend that _____ be awarded ___hours of donated leave from the Government of the Virgin Islands Donated Leave Program.

_____ _____ _____
Division of Personnel Representative Date Date

*_Illness is defined as any illness or injury to the employee or to a member of an employee's family which is diagnosed by a physician and certified by the physician as rendering the employee or the member of the employees family unable to work, or in the case of family member who does not work the medical equivalent of "unable to work" for a period greater than 3 calendar weeks._

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Physician's Statement for Employees Requesting Paid Leave(s)

Note: This Page is CONFIDENTIAL

Section #1 is to be completed by employee.

1. Name of Patient: _____ Date of Birth : _____

Patient's Relationship to Employee ☐ Self ☐ Family Member (designate)

Present Address: _____

Type of Leave being requested
- ☐ Donate Leave for self
- ☐ Donate Leave for family
- ☐ Leave for Military Illness/Injury* **(applies to employee only)**

Following to be completed by physician who is treating the employee or employee's family member

Section #2 ONLY applies to Donated Leave for family

2. If patient is the employee's seriously ill family member please complete the following:
   - Is hospitalization of family member (patient) required? ☐ Yes ☐ No
   - Does (or will) patient need help for basic medical, hygiene, nutrition, safety or transportation? ☐ Yes ☐ No
   - Is the employee's presence necessary, or would it be beneficial for care of the patient? ☐ Yes ☐ No
   - Please describe the care required and the estimated time allotted for treatment and recovery.

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

This patient is responsible for the completion of this form without expense to the Government of the Virgin Islands. We must have comprehensive medical information in order to evaluate his/her claim for donated leave benefit

3. HISTORY

(a) When did the symptoms first appear or injury happen? **Mo.** _____ **Day** _____ **Yr. 20** _____

(b) Date disability began **Mo.** _____ **Day** _____ **Yr. 20** _____

(c) Has patient ever had same or similar condition? ☐ **Yes** ☐ **No**

If "yes" please give details _____

(d) Is condition due to serious illness or injury arising out of patient's employment? ☐ **Yes** ☐ **No** ☐ **Unknown**

(e) Did the patient suffer this serious illness or injury in the line of duty that was caused or contributed to by war or act of war (declared or not)? ☐ **Yes** ☐ **No** ☐ **Unknown**

***Leave for military illness category is available for the employee only and not for family members**

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4. DIAGNOSIS (including any complications)

(a) When did the symptoms first appear or injury happen? **Mo.** _____ **Day** _____ **Yr.** **20** _____

(b) Diagnosis and ICD-9 or DSM-IV Code (including any complications)

_____

(c) Subjective symptoms

_____

(d) Objective findings (Including current x-rays, EKG's, Laboratory Data and any clinical findings)

_____

5. TREATMENT DATES

(a) Date of first visit **Mo.** _____ **Day** _____ **Yr.** **20** _____

(b) Date of last visit **Mo.** _____ **Day** _____ **Yr.** **20** _____

(c) Frequency ☐ Weekly ☐ Monthly ☐ Other(specify) _____

6. NATURE OF TREATMENT (including surgery and medications prescribed, if any)

Will treatment substantially improve function and employability? ☐ Yes ☐ No

If yes, please specify.

_____

7. PROGRESS

(a) Has patient ☐ recovered? ☐ improved? ☐ unchanged? ☐ retrogressed?

(b) Is patient ☐ bed confined? ☐ hospital confined? ☐ ambulatory? ☐ house confined?

(c) Has patient been hospital confined? ☐ Yes ☐ No

If yes, give name and address of hospital _____

Confined from _____ through _____

8. CARDIAC (if applicable)

(a) Functional capacity ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation)

(American Heart Assoc.) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

(b) Blood Pressure (last visit) ☐ Systolic ☐ Diastolic

9. LIMITATION (if there is a limitation, check and describe below)

☐ standing _____ ☐ walking _____ ☐ bending _____ ☐ use of hands _____

☐ climbing _____ ☐ sitting _____ ☐ lifting _____ ☐ stooping _____

☐ psychological _____ ☐ other _____

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10. PHYSICAL IMPAIRMENT (as defined in Federal Dictionary of Occupational Titles)

☐ Class 1 – no limitation of functional capacity; capable of heavy work. No restrictions (0-20%)

☐ Class 2 – medium manual activity (15-30%)

☐ Class 3 – slight limitation of functional capacity; capable of light work (35-55%)

☐ Class 4 – moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity (60-70%)

☐ Class 5 – severe limitation of functional capacity; incapable of minimal (sedentary) activity (75-100%)

Remarks: _____

_____

_____

_____

Do you believe the patient is competent to endorse checks and use the proceeds thereof? ☐ Yes ☐ No

11. EXTENT OF DISABILITY

		From Patient's Regular Occupation	From any Occupation
(a)	Is patient now totally disabled?	☐ Yes ☐ No	☐ Yes ☐ No
(b)	If no, when was patient able to go to work?	**Mo.** _____ **Day** _____ **Yr. 20** _____	
(c)	If yes, when do you think patient will be able to resume any work?	**Mo.** _____ **Day** _____ **Yr. 20** _____	

12. REMARKS

_____

_____

_____

_____

_____

_____ _____ _____ _____

Date Signature (attending physician) Degree Telephone Number

Upon completion, please forward to applicant's agency personnel/payroll office.