STATE OF WEST VIRGINIA
APPLICATION FOR LEAVE FOR FEDERAL FAMILY and MEDICAL LEAVE, STATE PARENTAL LEAVE, and/or MEDICAL LEAVE OF ABSENCE WITHOUT PAY

(Note: FMLA can be paid or unpaid; Parental Leave and Medical Leave of Absence are unpaid)

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, and/or MEDICAL LEAVE WITHOUT PAY FOR THE FOLLOWING REASON:

- ☐ Personal Illness
- ☐ Birth of a Child
- ☐ Military Caregiver
- ☐ Illness of Family Member - Specify Member:_____
- ☐ Adoption/Foster Child Placement
- ☐ Qualifying Exigency Military

PERIOD OF LEAVE:	**TO BE TAKEN:**
FROM Date: _____ _____ ☐ A.M. ☐ P.M.	☐ Continuously
TO Date: _____ _____ ☐ A.M. ☐ P.M.	☐ Intermittently*

I AM REQUESTING THE LEAVE BE PAID AND/OR UNPAID AS FOLLOWS:

_____ Hours Paid (annual) _____ Hours Paid (sick) _____ Hours Unpaid

Appropriate, available paid sick and annual leave must be used to cover leave taken for FMLA qualifying events.

EMPLOYEE SIGNATURE:	**APPLICATION DATE:**
☐ Approved **IMMEDIATE SUPERVISOR SIGNATURE:** ☐ Disapproved DATE:	☐ Approved **AGENCY-AUTHORIZED SIGNATURE:** ☐ Disapproved DATE:

*** IF INTERMITTENT LEAVE IS BEING REQUESTED, PLEASE SPECIFY DATES AND TIMES:**

NOTE: In addition to the leave available under the federal Family and Medical Leave (FMLA) and State Parental Leave Acts, the Division of Personnel's *Administrative Rule*, W. VA. CODE R. §143-1-1 *et seq.*, also provides for leave, both paid and unpaid, if an employee meets eligibility requirements and requests the leave for a qualifying event. If the leave qualifies under both the federal and State law, and/or the *Administrative Rule*, the leave entitlement under each will exhaust concurrently. A completed and current DOP-L3, DOP-L5, DOP-L6, DOP-L7, or DOP-L8 certification, as applicable, must be included with this application or be on file. Form DOP-L7 or DOP-L8, as applicable, is required when requesting Military FMLA leave.

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

☐ 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; **do not include medical information/diagnosis when requesting leave for illness**):

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:

- 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 medical leave of absence without pay under the Division of Personnel's Administrative Rule, W. VA. CODE R. §143-1-1 et seq., and/or leave with or without pay under the federal Family and Medical Leave or State Parental Leave Acts. Instead, use forms DOP-L3 through DOP-L8 (as applicable).

STATE OF WEST VIRGINIA
MEDICAL LEAVE OF ABSENCE WITHOUT PAY and/or
FEDERAL FAMILY and MEDICAL LEAVE ACT (FMLA)

Supplemental Certification of Health Care Provider for Employee's Serious Health Condition

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: This form should be required when Form DOP-L3 does not provide sufficient information. In accordance with the West Virginia Division of Personnel *Administrative Rule*, W. VA. CODE R. §143-1-1 *et seq*., and the Family and Medical Leave Act (FMLA), an employer may require an employee seeking leave and/or FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. §1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer Name: _____ Contact Phone: _____

Employee's Job Title: _____ Regular Work Schedule: _____

Employee's Essential Job Functions: _____

☐ Check if job description is attached.

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The *Administrative Rule* and FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your leave request. 20 C.F.R. §825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. §825.305(b).

EMPLOYEE NAME: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the *Administrative Rule* of the Division of Personnel and/or FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Page 4 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ No ☐ Yes If so, dates of admission:

   _____

   Date(s) you treated the patient for condition: _____

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition?
   ☐ No ☐ Yes

   Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ No ☐ Yes If so, state the nature of such treatments and expected duration of treatment: _____

   _____

2. Is the medical condition pregnancy? ☐ No ☐ Yes If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition:
   ☐ No ☐ Yes If so, identify the job functions the employee is unable to perform:
   _____
   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
   _____
   _____
   _____
   _____
   _____
   _____
   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ No ☐ Yes

   If so, estimate the beginning and ending dates for the period of incapacity:

   FROM: _____ TO: _____ (required)

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ No ☐ Yes

   If so, are the treatments or the reduced number of hours of work medically necessary?
   ☐ No ☐ Yes

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:
   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:
   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ No ☐ Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?
☐ No ☐ Yes If so, explain: _____
_____
_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

8. 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?
☐ No ☐ Yes

If yes, what is the period of partial incapacity? FROM _____ TO _____

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. Use reverse if necessary.

_____
_____
_____
_____

Will this condition permanently prevent the employee from performing his/her duties?
☐ No ☐ Yes

ADDITIONAL INFORMATION (Identify question number with your additional answer):

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Signature of Health Care Provider Date

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 _____

Dates of treatment: _____

PERIOD OF INCAPACITY (required): FROM _____ TO _____

❑ NO ❑ YES During this time, will or did the patient need care?

If yes, explain the care needed by the patient and why such care is/was medically necessary. Use reverse side if needed.

_____

_____

_____

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EMPLOYEE LIMITATIONS/RESTRICTIONS (skip if patient was a family member of the employee):

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

Date: _____

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

If yes, what is the period of partial incapacity? FROM _____ TO _____

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. Use reverse side if needed.

_____

_____

_____

❑ NO ❑ YES Will this condition permanently prevent the employee from performing his/her duties?

PHYSICIAN/PRACTITIONER INFORMATION:

NAME OF PRACTICE: TELEPHONE:

TYPE OF PRACTICE/MEDICAL SPECIALITY:

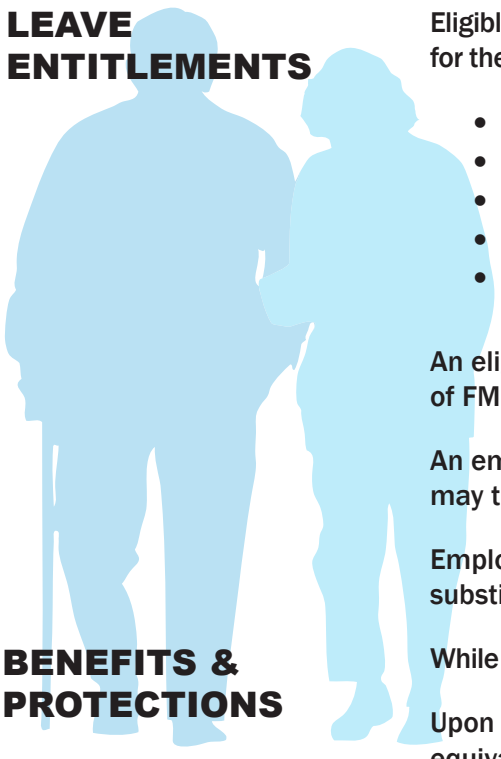
ADDRESS:

SIGNATURE:

NOTE: When requesting a medical leave of absence without pay under the Division of Personnel's *Administrative Rule*, W. VA. CODE R. § 143-1-1 *et seq*., and/or leave with or without pay under the federal Family and Medical Leave or State Parental Leave Acts, certification forms DOP-L5 or DOP-L6, as applicable, may be required if additional information is needed.

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

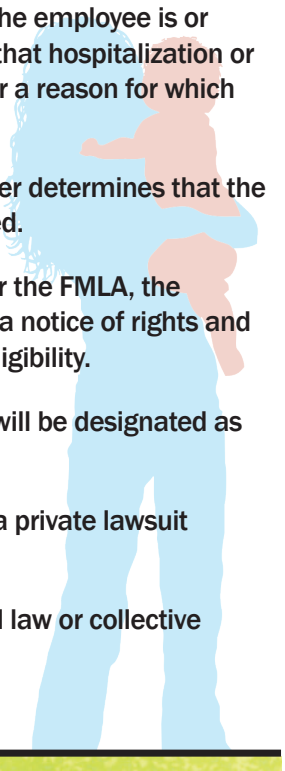
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WAGE AND HOUR DIVISION

WH1420 REV 04/16

West Virginia Division of Personnel

LEAVE DONATION PROGRAM
APPENDIX A

APPLICATION TO RECEIVE DONATED LEAVE

PLEASE PRINT OR TYPE

PART I – APPLICANT INFORMATION: To be completed by the applicant or designee.

Name:	Social Security Number:	
Agency:	Work Phone:	Home Phone:
Section (and Unit if applicable):		

Reason for Request:
☐ Employee's Personal Medical Condition
☐ Immediate Family Member's Medical Condition
Relationship:

The reason for the request **must** be verified by the physician or medical practitioner treating the individual with the medical condition. The physician or medical practitioner must provide all of the information requested on the back of this form (PART III), and he/she must sign and date the form.

In applying for leave donations, I agree to have the following information published:

- My Name
- The agency for which I work
- My last day at work
- The date my available leave was/will be exhausted
- The reason for my absence
- The expected duration of my absence

Signature Date:

Completed by: ☐ Applicant ☐ Designee (specify):

OPTIONAL - To be completed ONLY by the applicant: As part of my application for leave donations, I further request that you also publish the following information regarding my medical emergency, exactly as I have written it in the space below:

Signature Date:

PART II – EMPLOYER DETERMINATION: To be completed by the applicant's Appointing Authority or designee.

1. Does the applicant receive annual and sick leave as a benefit of employment?	☐ YES	☐ NO
2. For this absence: Is the applicant receiving/eligible to receive Worker's Compensation benefits, or is he/she receiving Social Security Disability benefits?	☐ YES	☐ NO
3. The applicant's available leave for this absence was/will be exhausted on:	Date:	
4. The applicant, according to the information provided in PART III of this form, is expected to be absent from work through:	Date:	
5. This leave of absence is for the following reason:	☐ Medical Condition: Employee ☐ Medical Condition: Immediate Family Member	
6. The applicant's eligibility determination is:	☐ ELIGIBLE	☐ NOT ELIGIBLE: explain below
7. OASIS account information for recipient:		
8. Certified by:	10. Phone:	
9. Title:	11. Date:	

PART III – PHYSICIAN/PRACTITIONER INFORMATION: To be completed by the patient's physician or medical practitioner.

The employee named in Part I has applied to receive donations of annual leave through the Leave Donation Program established by the West Virginia Division of Personnel. You are requested to either complete the information below or attach a completed DOP-L3 Physician's/Practitioner's Statement form for your patient.

If your patient is the named employee, complete items 1, 2, 3, 4a, 5a, and 6 through 13. If your patient is a member of the named employee's immediate family, complete items 1, 2, 3, 4b, 5b, and 9 through 13.

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PLEASE PRINT OR TYPE

<table>
<tr><td colspan="2">1. Patient's Name:</td><td colspan="2">2. Most recent examination date:</td></tr>
<tr><td colspan="2">3. Patient is/was:
☐ Under my professional care
☐ Hospitalized</td><td>FROM
FROM</td><td>TO
TO</td></tr>
<tr><td colspan="4">4 and 5. COMPLETE THE APPROPRIATE SECTIONS (4a and 5a –OR– 4b and 5b) BELOW: Provide a return to duty date for either section, even if it is approximate. As an alternative, you may give the date you will next evaluate the patient's condition.</td></tr>
<tr><td colspan="2">4a. Patient is:
☐ The employee, and has been incapacitated from performing and is/her job duties
FROM TO
5a. Return to duty information: The patient/employee has resumed or may resume full duty employment, with no restrictions on work activities, on:
DATE:</td><td colspan="2">4b. Patient is:
☐ A family member of the named employee, and the employee's absence from work has been necessitated by the medical condition of the patient
FROM TO
5b. Return to duty information: The patient will no longer need the care/attendance of the named employee, which would require the absence of the employee, on:
DATE:</td></tr>
<tr><td colspan="2">6. If the patient is not able to return to full duty employment, can he/she return to work at less than full duty?
If yes, what is the period of incapacity?</td><td>☐ YES
FROM</td><td>☐ NO
TO</td></tr>
<tr><td colspan="4">7. Describe in detail any limitations or restrictions on the ability of the employee to work. Please list any assistive devices or equipment, or any other type of accommodation, the employee requires in order to perform his or her job duties.</td></tr>
<tr><td colspan="2">8. Will this illness/injury permanently prevent the employee from returning to work?</td><td>☐ YES</td><td>☐ NO</td></tr>
<tr><td colspan="4">9. Physician's or Medical Practitioner's Name:</td></tr>
<tr><td colspan="3">10. Address:</td><td>12. Phone:
13. Fax:</td></tr>
<tr><td colspan="3">11. Signature</td><td>14. Date:</td></tr>
</table>