Government of the Virgin Islands
REQUEST FOR OR NOTIFICATION ABSENCE

PP #	Fiscal Year

(1) Employee's Name (Last, First M.I.)	(2) Social Security No.	(4) Date Submitted	(5) No. of Hours Requested

(3) Agency/Division	Account/Activity Code	(6) From Date

(7) Time of Call or Request	(8) Scheduled Reporting Time	(9) Employee Can Be Reached At (If Needed) (10) ☐ No Call	Thru Date

(11) Type of Absence
- ☐ Sick (See Reverse)
- ☐ Annual
- ☐ LWOP (See Reverse)
- ☐ Maternity
- ☐ Comp
- ☐ Personal_

(12) Documentation (for Official Use Only)
- ☐ For Military Leave (Order Reviewed)
- ☐ For court Leave (Summons Reviewed)

(13) Revised Scheduled for _____ (Date) Approved in Advance ☐ Yes ☐ No

(14) Remarks – (Do Not Enter Medical Information)

I Understand that the annual leave authorized in excess of amount available of me during the leave year will be charged to LWOP

		Scheduled	Unscheduled	Day	Init.	Hours
				Sun 01		
Begin Work				Mon 02		
Lunch-Out				Tue 03		
Lunch-In				Wed 04		
End Work				Thur 05		
Total Hours				Fri 06		
				Sat 07		
				Sun 08		
				Mon 09		
				Tue 10		
				Wed 11		
				Thur 12		
				Fri 13		
				Sat 14		

(15) Employee's Signature & Date	(16) Signature of Person Recording Absence & Date	(17) Signature of Supervisor & Date Notified

Official Action on Application

(18) ☐ Approved ☐ Disapproved (Give Reason)	(19) Signature if Supervisor & Date

Warning: The Furnishing of false information on the form may result in Criminal Action under V.I. Criminal Status:

☐ Continued on Reversed

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During This Absence, I was Incapacitated for Duty By:

- ☐ Sickness
- ☐ On The Job Injury
- ☐ Off The Job Injury
- ☐ Pregnancy or/&
- ☐ Confinement
- ☐ Caring for Patient (or) Exposed to A Contagious Disease
- ☐ Undergoing Medical Denial or Optical Examination or Treatment

Privacy Act: This information will be used to grant or deny your request for official leave from V.I. Government service duty. As a routine use, this information may be disclosed to an appropriate law enforcement agency for investigative or prosecutorial proceedings, to any agency where relevant to hiring, contracting or licensing, to a labor organization as may be required, to the Equal Employment Opportunity Commission for investigation of an EEO complaint, and where pertinent. In a legal proceedings to which the V.I. Government is a party. Completion of this form is voluntary. However, if this information is not provided, official leave may not be granted.

CERTIFICATE OF PHYSICIAN OF PRACTITIONER

I certify that _____has been under my Professional care and that he/she was incapacitated for work

from _____, 20_____
(Month and Day)

thru _____, 20_____
(Month and Day)

_____ _____
(Signature) (Date)

_____
(Name)

_____
(Address)

_____

REMARKS:

PP #	Fiscal Year	
Day	Init.	Hours
Sun 01		
Mon 02		
Tues 03		
Wed 04		
Thur 05		
Fri 06		
Sat 07		
Sun 08		
Mon 09		
Tue 10		
Wed 11		
Thur 12		
Fri 13		
Sat 14		

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