DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Leave of Absence Application Form

Use this document to request all application leaves which require approval from Human Resources (HR): Family and Medical Leave (FMLA), Extended Leave (EL) and Paid Family Leave (PFL). Note that in order to apply for PFL, you also must apply and be approved for either FMLA or EL. Please place a checkmark by all required leave types. See the Frequently Asked Questions at http://dcps.dc.gov/DCPS/About+DCPS/Human+Resources/FAQs/Leave+of+Absence for more information.

☐ **Request for FMLA** ☐ **Request for EL** ☐ **Request for PFL**

I. Applicant Information

Full Name: (Print Clearly)	LAST FIRST MI	Employee ID #:	
Mailing Address:	STREET ADDRESS APARTMENT/UNIT #		
City, State:		Zip Code:	
Home Phone:		Mobile/Alt. Phone:	
Home Email:			
Date of Birth:		Social Security #:	
School or Department:		Position Title:	
Principal or Supervisor:			

II. Emergency Contact Information

Full Name:	FIRST LAST	Relationship:	
Primary Phone:		Alternate Phone:	

III. Consent to Contact Healthcare Provider

I hereby request and authorize _____ **(Insert Physician's Name)** to release and send to Benefits & Compensation (HR), District of Columbia Public Schools, the following information, which s/he may have about me/my family member:

The medical condition/impairment for which I may need a leave of absence, including its nature, severity, and duration, limitations of the condition/impairment, and job functions affected by the condition/impairment

I understand that this information is required to help determine whether I or my family member has a serious health condition, and if so, its effect on work activities, and any needs for Medical/Family Leave to care for the condition. This information will be used for this purpose only and will be kept confindential. I have read the above and am satisfied with the reason and purpose for which my permission is given.

_____ _____

Employee Signature *Date*

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IV. Reason for Leave Request

Non-PFL Qualifying Events

- ☐ My personal health conditon
- ☐ Exigency Military Leave

PFL Qualifying Events

- ☐ Legal placement of a child, e.g. adoption, guardianship, or foster care
- ☐ Placement of a child for whom the employee assumes and discharges parental responsibilities
- ☐ Birth of the child of the employee
- ☐ Care of an employee's family member who has a serious health condition
- ☐ Military Caregiver Leave

V. Physician's Statement

This section MUST be completed by the attending physician.
I hereby certify that I am the attending physician for the family member of this applicant or for the employee who has applied for an approved Leave of Absence. **[Please print clearly.]**

Based upon my professional evaluation, the expected return date is:			
Physician Name: (Print)		Office Phone:	
Physician Signature:		Date:	

VI. Employee Signature

ALL EMPLOYEES:

I understand that per my leave request type, I am required to provide official documentation to HR at the time of application and upon my return. Without official documentation, HR has the right to deny my request for leave or to return to work at any time.

I understand that I must provide HR with advance written notice 30 days prior to the expiration of my Leave of Absence of my intention to return to District of Columbia Public Schools. I further understand that my failure to return to duty following the expiration of my Leave of Absence may be construed as my voluntary resignation.

I understand that my benefits premiums will continue to be paid during my Leave of Absence, including during any periods of non-pay. Upon my return to work it is my responsibility to contact the Office of Pay and Retirement Services (OPRS) to arrange for payment of missed premiums.

_____ _____

Employee Signature *Date*

VII. Approval

NOTE: Only the Director, Benefits & Compensation can approve Leave of Absence requests. Your request is not approved until you receive a letter from the Director, Benefits & Compensation.

_____ _____

Director, Benefits & Compensation Signature – Approval *Date*

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This section must be completed by the employee.

VIII. Identification Information

Employee Name:	LAST FIRST MI		
Social Security #:		Employee ID #:	
Agency:	**District of Columbia Public Schools**	Department:	

IX. Family Leave

A. I hereby request _____ hours of Family Leave for one of the following purposes:

☐ The birth of the child of the employee

☐ The placement of a child for whom the employee assumes and discharges parental responsibilities

☐ Legal placement of a child, e.g. adoption, guardianship, or foster care

☐ Care of an employee's family member who has a serious health condition

☐ Military Caregiver Leave

B. I hereby request the following type(s) of pay for my Family Leave. I understand that I may elect to use my paid leave at my discretion, and that it will count against my total 16-workweek entitlement to Family Leave.
Check appropriate box(es):

☐ Annual Leave: Number of Hours:_____

☐ Sick Leave: Number of Hours:_____

☐ Universal Leave (Chancellor's Management Team Only): Number of Hours:_____

☐ Paid Family Leave: Number of Hours:_____

☐ Leave Bank Hours (WTU Only): Number of Hours:_____

☐ Advanced/Donated Leave: Number of Hours:_____

When I exhaust my paid leave, or in lieu of using paid leave, I understand that I will be in unpaid leave status. I hereby request to use _____ hours of Leave Without Pay.

C. The period of Family Leave requested in IX.A. above is to be taken:

☐ In a continuous block of time from _____ to _____.

☐ On a reduced leave schedule as mutually agreed with my agency from _____ to _____. I understand that the 16 weeks of FMLA - Family Leave on a reduced leave schedule must be taken within a period that does not exceed 24 consecutive workweeks.

☐ Intermittently in accordance with paragraph 8(d) of DPM Instruction No.12-16.

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Summary of Family Care

State the care you will provide and an estimate of the period during which care will be provided, including schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

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X. Complete if Applying for Medical Leave

A. I hereby request _____ hours of Medical Leave due to my serious health condition.

B. I hereby request the following type(s) of pay for my Medical Leave. I understand that I may elect to use my paid leave at my discretion, and that it will count against my total 16-workweek entitlement to Medical Leave.
Check appropriate box(es):

☐ Annual Leave: Number of Hours:_____

☐ Sick Leave: Number of Hours:_____

☐ Universal Leave (Chancellor's Management Team Only): Number of Hours:_____

☐ Paid Family Leave: Number of Hours:_____

☐ Leave Bank Hours (WTU and CSO Only): Number of Hours:_____

☐ Advanced/Donated Leave: Number of Hours:_____

When I exhaust my paid leave, or in lieu of using paid leave, I understand that I will be in unpaid leave status. I hereby request to use _____ hours of Leave Without Pay.

C. The period of family leave requested in X.A. above is to be taken:

☐ In a continuous block of time from _____ to _____.

☐ On a reduced leave schedule as mutually agreed with my agency from _____ to _____. I understand that the 16 weeks of FMLA - Medical Leave on a reduced leave schedule must be taken within a period that does not exceed 24 consecutive workweeks.

☐ Intermittently in accordance with paragraph 8(d) of DPM Instruction No.12-16.

Please see page 6 for listing of required documentation.

XI. Employee Certification

I certify that the above statements are true to the best of my knowledge:

_____ _____
Signature Date

☐ **APPROVED** ☐ **DENIED**

TO BE COMPLETED BY HUMAN RESOURCES

Reviewed by:

_____ _____
Signature **Date**

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XII. Documentation Required

You will be required to provide documentation in support of this application. Below are the types of documentation that are generally required. However, you may be asked to provide any additional documentation to support your application.

If you are requesting …	**You must provide …**
Leave for a personal health condition	Certificate of Health Care Provider for Employee's Serious Health Condition (DOL-WH-380-E)
Birth of your child	Medical certification of anticipated birth or birth certificate
Adoption of a child or other legal placement	Certified court order(s) of placement
Assumption of parental duties for a child	Official records of parental responsibilities (such as school parental designation)
Caring for a family member	Certificate of Health Care Provider for Family Member's Serious Health Condition (DOL-WH-380-F)
Exigency Military Leave	Certification of Qualifying Exigency for Military Family Leave (DOL-WH-384)
Military Caregiver Leave	Certification of Serious Injury or Illness of Current Service Member – Military Family Leave (DOL-WH-385) – OR Certification of Serious Injury or Illness of a Veteran for Military Caregiver Leave (DOL-WH-385-V)

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Definitions

The Family and Medical Leave Act (FMLA) provides job-protected absence from work for a certain period of time to employees who meet the minimum years of service and qualifying event requirements. DCPS employees may be eligible for provisions set forth by both Federal FMLA and DC FMLA.

Paid Family Leave (PFL) provides eligible District Government employees with up to eight weeks of Paid Family Leave within a 12-month period for the birth or placement of a child with an employee, or to care for a family member.

Extended Leave (EL) provides non-job protected leave to employees who wish to request leave under FMLA (Federal/DC) but are ineligible for the following reasons:

- Employee does not meet the minimum time in-service requirement
- Employee has exhausted the maximum length of leave of absence time allowed

A ***"Serious Health Condition"*** means an illness, injury, impairment, or physical or mental condition that involves one of the following:

-**Inpatient Care**
In a hospital, hospice, or residential health care facility.(e.g. an overnight stay)

-**Continuing Treatment**
Required by a Health Care Provider (e.g. physical therapy)

-**Pregnancy**
(e.g. ongoing pregnancy, miscarriages, complications or illnesses related to pregnancy prenatal care, childbirth, recovery from childbirth).

-**Chronic Conditions**
Requiring treatments by a Health Care Provider (e.g. asthma, diabetes, epilepsy)

-**Permanent/Long-Term Conditions**
Requiring supervision by a Health Care Provider
(e.g. Alzheimer's, a severe stroke, terminal stages of a disease)

-**Multiple Treatments (Non-Chronic Conditions)**
Required by a Health Care Provider
(e.g. chemotherapy, radiation, dialysis)

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This section must be completed by the attending physician. When completed, this form must be returned to the employee.

1. Employee's Name	2. Patient's Name (if different from employee)

3. Page 11 describes what is meant by a **"serious health condition"** under the D.C. Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

   (1)_____ (2)_____ (3)_____ (4)_____ (5)_____ (6)_____ or None of the Above _____

4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the categories:

5. a. State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity,**[2] if different):

   b. Will it be necessary for the employee to work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in item 6 below)?

   If yes, give the probable duration:

   c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated[2] and the likely duration and frequency of **episodes of incapacity**[2]**:**

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is applying for FMLA leave.

[2] "Incapacity", for purposes of FMLA, is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatement therefore, or recovery therfrom.

6. a. If additional **treatment(s)** will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by **another provider of health services** (e.g. physical therapist), please state the nature of the treatments:

c. **If a regimen of treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g. prescription drugs, physical therapy requiring special equipment):

7. a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work** of any kind?

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment?

8. a. If leave is required to care **for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

_____	_____
Name of Health Care Provider (print clearly)	Type of Practice
_____	_____
Signature of Health Care Provider	Date
_____	_____
Address	Telephone Number
_____	_____

A **"Serious Health Condition"** means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. **Inpatient Care**
   In a hospital, hospice, or residential health care facility
   (e.g. an overnight stay)

2. **Continuing Treatment**
   Required by a Health Care Provider[3]
   (e.g. physical therapy)

3. **Pregnancy**
   (e.g. ongoing pregnancy, miscarriages, complications or illnesses related to pregnancy, prenatal care, childbirth, recovery from childbirth)

4. **Chronic Conditions**
   Requiring treatments by a Health Care Provider
   (e.g. asthma, diabetes, epilepsy)

5. **Permanent/Long-Term Conditions**
   Requiring supervision by a Health Care Provider
   (e.g. Alzheimer's, a severe stroke, terminal stages of a disease)

6. **Multiple Treatments (Non-Chronic Conditions)**
   Required by a Health Care Provider
   (e.g. chemotherapy, radiation, dialysis)

COMPLETED FORM MUST BE RETURNED TO THE EMPLOYEE.

[3] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations or dental examinations.

A regimen of continuing treatment includes, for example, a course of prescription medication (e.g. an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.