DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

APPLICATION FOR FAMILY LEAVE OR MEDICAL LEAVE OF ABSENCE

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

II. Emergency Contact Information			
Full Name:	FIRST LAST	Relationship:	
Primary Phone:		Alternate Phone:	

III. Leave Request Information

I hereby make application for leave under the authority of the District of Columbia Family and Medical Leave Act of 1990 (D.C. Law 8-181; D.C. Official Code § 32-501 *et seq.*), Chapter 16 of Title 4, District of Columbia Municipal Regulations, and DPM Instruction No. 12-16.

Check one: ☐ FAMILY LEAVE ☐ MEDICAL LEAVE

I intend to begin my leave on the following date:		I intend to return to work on the following date:	

In compliance with the rules of the Board of Education for employees requesting a leave of absence, the applicant is required to provide specified documents to the Office of Human Resources at the time of the leave request.

The maximum leave entitlement for Family Leave or Medical Leave is sixteen (16) weeks.

- **Family Leave:** The request for family care leave must be supported by a certificate of the serious health condition(s) issued by the family member's health care provider.
- Per the District of Columbia Family and Medical Leave Act of 1990, the period of time following the birth of a child is considered family leave.
- **Medical Leave:** The request for medical leave must be supported by attending physician's statement and the applicant has been examined and will be mentally, physically and emotionally able to resume their duties on the designated return date.

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IV. 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 Family or Medical Leave of Absence. **[Please print clearly.]**

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

V. Employee Signature

ALL EMPLOYEES:
I understand that per my leave request type, I am required to provide official documentation to the Office of Human Resources (OHR) at the time of application and upon my return when necessary. Without official documentation which I must provide, OHR has the right to deny my request for leave or return at any time.

I understand that I must provide OHR advance written notice thirty (30) days prior to the expiration of my leave of absence of my intent to return to the District of Columbia Public Schools. I further understand that my failure to return to duty following the expiration of leave of absence may be construed as my voluntary resignation.

I understand that I am responsible for my share of the payments of benefits premiums during non-pay status. It is my responsibility to contact the DCPS Office of Human Resources – Benefits Unit to arrange payment for missed premiums.

ET-15 EMPLOYEES ONLY:
I understand that all ET-15 or other classroom based employees may be required by the Office of Human Resources to duty at the beginning of a semester following an extended leave of absence.

Employee Signature *Date*

VI. Approval

NOTE: Only the Director of the DCPS Office of Human Resources can approve Family and Medical Leave requests. Your request is not approved until you receive a letter from the Director of the DCPS Office of Human Resources.

Director of Human Resources Signature – Approval *Date*

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EMPLOYEE HEALTH BENEFITS OPTIONS WHILE IN NON-PAY STATUS

I. Personal Information

Employee Name:	LAST MI FIRST	Employee ID:	
Health Benefit Plan:		Type of Coverage (circle one):	**SELF SELF+1 FAMILY**
Effective Leave Start Date:		Effective Return to Duty Date:	

II. Benefits Information

The US Office of Personnel Management and District Government permit an employee to continue participation in their health benefits program for 365 days while in a non-pay status.

Each pay period you are enrolled in the FEHB (Federal Employee Health Benefits) or DCEHB (District of Columbia Employee Health Benefits) Program, you are responsible for payment of the employee's share of the premium. When you enter non-pay status, it is insufficient to cover the premium payment. You must elect one of the following options:

Continue the Enrollment and Agree to Pay the Premiums: If you elect to continue your coverage and agree to pay the premiums, you must pay the premiums directly to your personnel office. To make direct payments to your personnel office, mail a money order or cashier's check payable to DC Treasury. Your name, social security number, and the pay period for which the payment is being made should be included on your check or money order. You must also notate that the payment is for FEHB or DCEHB Premiums. A payment coupon is available through your personnel office for your use and may be submitted with each payment.

Continue the Enrollment and Incur a Debt: If you elect to continue the enrollment and incur a debt in the amount of the unpaid premiums OR if you elect to make a direct payment but fail to pay the entire amount due, you will receive a notice stating the total amount due. The notice will be sent to you when you return to pay status, your pay becomes sufficient, you separate from employment or you have completed 365 days in a non-pay status. By electing to continue coverage you agree to repay the resulting debt in full and allow the debt to be collected by withholdings from any salary payments to you from DC Government. If the amount due cannot be withheld in full from salary, it will be recovered from a lump sum payment or accrued leave, income tax refunds, amounts payable under the Civil Service Retirement or Federal Employees Retirement System. If you choose not to return to DCPS following a leave of absence, you are still required to pay the debt. *This is not an option for employees enrolled in Kaiser Permanente.*

Terminate the Enrollment: If you elect to terminate your enrollment (or the enrollment automatically terminates), the termination will take effect at the end of the last pay period in which premiums were withheld from pay. FEHB and DCEHB coverage will continue at no cost to you for an additional 31 days. During the 31-day period, you and your covered family members may convert to a non-group contract. The termination is not considered a break in continuous coverage which is necessary for continuing FEHB or DCEHB coverage into retirement. However, the period during which the termination is in effect does not count toward satisfying the required five years of continuous coverage. When you return to pay and duty status or at the end of the first period your pay becomes sufficient to cover your premium, you must re-enroll within 31 days if you want FEHB or DCEHB coverage.

I hereby certify that I have read the notice above and I understand my health benefits options while in a non-pay status. Based on what I have read, I have elected to enroll in the following option:

☐ Continue the enrollment and agree to pay premiums ☐ Incur a debt ☐ Terminate the Enrollment

Please note: You must respond within 31 days of this notice (45 days for employees residing overseas) or your FEHB and DCEHB enrollment will automatically terminate.

Employee Signature *Date*

* The Federal (FEHB) and District (DCEHB) Kaiser Permanente Health Plans do not offer the "Incur a Debt" option. Employees enrolled in either of these plans must elect to continue to pay premiums or to terminate the enrollment.

DISTRICT OF COLUMBIA GOVERNMENT REQUEST FOR FAMILY/MEDICAL LEAVE

TO BE COMPLETED BY THE EMPLOYEE:

I. Identification Information

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

II. Category of Leave Requested

I hereby make application for leave under the authority of the District of Columbia Family and Medical Leave Act of 1990 (D.C. Law 8-181; DC Official Code § 32-501 *et.seq.*), Chapter 16 of Title 4, District of Columbia Municipal Regulations, and DPM Instruction No.12-16.

Check One: ☐ FAMILY LEAVE ☐ MEDICAL LEAVE

III. Complete if Applying for Family Leave

A. I hereby request _____ hours of family leave for one of the following purposes:

☐ The birth of my child

☐ The placement of a child within my home for adoption or foster care

☐ The placement of a child within my home for whom I will discharge and assume parental responsibility

☐ To provide care for a family member who has a serious health condition

B. I am requesting the following type(s) of leave for family leave. (I understand that I may elect to use my accrued annual leave, and/or compensatory time for family leave and, in so using this leave, any annual leave, and/or compensatory time will count against my total 16-workweek entitlement to family leave.)
Check appropriate box(es):

☐ Annual Leave: Number of Hours _____

☐ Compensatory Time Off: Number of Hours _____

☐ Leave Bank Hours: Number of Hours _____

☐ Leave Without Pay: Number of Hours _____

☐ Sick Leave: Number of Hours _____

Total Hours _____

If this application is to provide care for a family member, a medical certification of the "serious health condition", issued by your family member's health care provider, must be attached to this application.

Note: ET-15 Employees are only entitled to request sick leave, leave without pay, or (WTU) leave bank hours.

C. The period of family leave requested in 3A above is to be taken:

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

☐ On a reduced leave schedule as mutually agreed to by my agency from _____ to _____. I understand that the 16 weeks of 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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IV. Complete if Applying for Medical Leave

A. I hereby request _____ hours of medical leave because of a serious health condition.

B. I am requesting the following type(s) of leave for medical leave. (I understand that I may elect to use my accrued sick leave, and, if agreed to by my agency, accrued annual leave, and/or compensatory time; and, in so using this leave, any sick leave, annual leave, and/or compensatory time will count against my total 16-workweek entitlement to medical leave.
Check appropriate box(es):

☐ Annual Leave: Number of Hours _____

☐ Compensatory Time Off: Number of Hours _____

☐ Leave Bank Hours: Number of Hours _____

☐ Leave Without Pay: Number of Hours _____

☐ Sick Leave: Number of Hours _____

Total Hours _____

Note: ET-15 Employees are only entitled to request sick leave, leave without pay, or (WTU) leave bank hours.

C. The period of family leave requested in 3A above is to be taken:

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

☐ Intermittently as medically necessary.

A medical certification of your "serious health condition", issued by your health care provider, must be attached to this application.

V. Health Benefit Information

Do you wish to continue your health benefits during the unpaid period of your family leave/medical leave entitlement?

☐ YES (I understand that I am responsible for continuing to pay my share of the health benefit premium.)

☐ NO (Attach declination of benefits form). I understand that by canceling my health benefits enrollment I cannot re-enroll in the health benefits program until the earlier of (1) the next health benefits "open season", or (2) upon satisfying a health benefits enrollment event.

VI. Certification

I certify that the above statements are true to the best of my knowledge and belief and that I am eligible to participate in the District of Columbia Family and Medical Leave Act.

_____ _____

Signature Date

TO BE COMPLETED BY HUMAN RESOURCES

☐ **APPROVED** ☐ **DISAPPROVED**

_____ _____

Signature of DCPS Human Resources Approving Official **Date**

DISTRICT OF COLUMBIA GOVERNMENT MEDICAL CERTIFICATION BY HEALTH CARE PROVIDER

Pursuant to the D.C. Family and Medical Leave Act of 1990

When completed, this form goes to the employee.

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

3. Page 4 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 taking 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, treatment therefore, or recovery therefrom.

6. a. If additional **treatments** 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 continuing 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

_____ _____

To be completed by the employee needing family leave to care for a family member:

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

_____ _____

Employee Signature Date

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)

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification.

COMPLETED FORM GOES 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.