**DISTRICT OF COLUMBIA GOVERNMENT**

**REQUEST FOR FAMILY/MEDICAL LEAVE**
**[District of Columbia Family and Medical Leave Act of 1990]**

**TO BE COMPLETED BY THE EMPLOYEE**

**1. IDENTIFICATION INFORMATION**

Name: _____
(Last) (First) (Middle)

Last 4 Digits of Social Security Number: _____

Position Title/Series/Grade: _____

Department or Agency: _____

Organization Code: _____

**2. 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; D.C. Official Code § 32-501 *et seq*.), Chapter 16 of Title 4, District of Columbia Municipal Regulations, and DPM Instruction No. 12-40.

(Check One): ❑ Family Leave ❑ Medical Leave

**3. TO BE COMPLETED 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 with me for adoption or foster care

❑ The placement of a child with me 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 _____ ❑ Exempt Time Off: Number of hours _____

❑ Leave bank hours: Number of hours _____ ❑ Leave without pay: Number of hours _____

❑ Voluntary Leave Transferred: Number of hours _____ **TOTAL NUMBER OF HOURS _____**

* (You must complete and attach form SF-71, "Application for Leave," when requesting this type of leave.)

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.

C. The period of family leave requested in Section 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 ___ of DPM Instruction No. 12-40.

Do you wish to continue your health benefits during the unpaid period of your family 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.

**4. TO BE COMPLETED 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.)

❑ *Sick leave: Number of hours _____

❑ *Annual leave: Number of hours _____

❑ *Compensatory time: Number of hours _____

❑ Exempt Time Off: Number of Hours _____

❑ Leave bank hours: Number of hours _____

❑ Leave without pay: Number of hours _____

❑ Voluntary Leave Transferred: Number of Hours _____

**TOTAL NUMBER OF HOURS** _____

* (You must file and attach form SF-71, "Application for Leave," when requesting this type of leave.)

C. The period of medical leave requested in Section 4A above is to be taken:

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

❑ Intermittently as medically necessary.

Do you wish to continue your health benefits during the unpaid period of your 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.

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

**5. EMPLOYEE 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 of 1990.

_____ _____

Signature Date

**TO BE COMPLETED BY THE EMPLOYING AGENCY:**

❑ Approved ❑ Disapproved

_____ _____

(Signature of Approving Official) Date