

## Leave of Absence Application Form

Use this medical certification to request all Leaves of Absence which require approval from Employee Services:

- 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.

If you are requesting Educational Leave or Charter School Leave, please provide additional supporting documentation. See the Frequently Asked Questions at [DCPS: Leave of Absence](#) for more information.

## **Documentation Required**

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

<i>If you are requesting leave for ...</i>	<i>You must provide ...</i>
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 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 required to follow the 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 who has a serious health condition.

A ***Qualifying Event*** under PFL is:

- a. Birth of a child of the employee;
- b. Legal placement of a child with the employee (such as through adoption, guardianship, or foster care);
- c. Placement of a child with the employee for whom the employee assumes and discharges parental responsibilities; or
- d. Care of an employee's family member who has a serious health condition.

***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***, under DC FMLA, is an illness, injury, impairment, or physical or mental condition that involves one of the following:

- (1) Inpatient Care
  - o In a hospital, hospice, or residential health care facility (e.g., an overnight stay)
- (2) Continuing Treatment
  - o Required by a Health Care Provider (e.g., physical therapy)
- (3) Pregnancy
  - o (e.g., ongoing pregnancy, miscarriage, complication or illness related to pregnancy, prenatal care, childbirth, and/or recovery from childbirth)
- (4) Chronic Condition
  - o Requiring treatment by a Health Care Provider (e.g., asthma, diabetes, epilepsy)
- (5) Permanent/Long-Term Condition
  - o Requiring supervision by a Health Care Provider (e.g., Alzheimer's, a severe stroke, terminal stage of a disease)
- (6) Multiple Treatments (Non-Chronic Conditions)
  - o Required by a Health Care Provider (e.g., chemotherapy, radiation, dialysis)

***Incapacity***, for purposes of FMLA, is defined as inability to work, attend school, or perform other regular daily activities due to a serious health condition, and/or treatment for and/or recovery from the serious health condition.

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## ***To Be Completed by Attending Physician***

When completed, this form must be returned to the employee. Note that all requested information relates only to the condition for which the employee is applying for Leave.

1. Employee Name	2. Patient's Name (if different from employee)
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**SERIOUS HEALTH CONDITION**. Complete this section if requesting leave for the employee's or a family member's serious health condition.

3.  
The previous page describes what is meant by a "serious health condition" under DC FMLA. Does the patient's condition qualify under any of the categories described? If yes, 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 the category checked above:

5.  
(a) Provide the date of the Qualifying Event (if applying for PFL), the approximate date (mm/dd/yyyy) that the condition commenced, and the probable end date of the condition:

Qualifying Event Date: \_\_\_\_\_  
(if applying for PFL) mm / dd / yyyy

Condition Start Date: \_\_\_\_\_  
mm / dd / yyyy

Condition End Date: \_\_\_\_\_  
mm / dd / yyyy

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**INTERMITTENT LEAVE.** Complete this section if the physician expects the employee to be absent from work and/or daily activities intermittently for illness, incapacity, and/or treatment. Additionally, complete this section if the employee must work a less than full-time schedule.

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

Yes \_\_\_\_\_

No \_\_\_\_\_

If yes, give the probable start and end date (mm/dd/yyyy) the employee must work intermittently or a less than full-time schedule:

Intermittent Work or Less Than Full-Time Schedule Start Date: \_\_\_\_\_  
mm / dd / yyyy

Intermittent Work or Less Than Full-Time Schedule End Date: \_\_\_\_\_  
mm / dd / yyyy

(c) If the condition is a pregnancy (condition (3) above) or chronic condition (condition (4) above), state whether the patient is presently incapacitated, the likely start and end date (mm/dd/yyyy) of incapacity, and the frequency of episodes of incapacity:

Incapacity Start Date: \_\_\_\_\_  
mm / dd / yyyy

Incapacity End Date: \_\_\_\_\_  
mm / dd / yyyy

Frequency of Episodes of Incapacity: \_\_\_\_\_

6.

(a) If the patient will be absent from work or other daily activities on an intermittent or part-time basis in order to seek treatment, provide an estimate of the number of and interval between such treatments, actual or estimated dates of treatment if known, and required recovery period, if any:

Estimated Number of Treatments: \_\_\_\_\_

Estimated Interval between Treatments: \_\_\_\_\_  
(e.g., every Tuesday, once every two weeks, etc.)

Treatment Dates: \_\_\_\_\_  
mm / dd / yyyy; mm / dd / yyyy; mm / dd / yyyy

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Recovery Start Date:

\_\_\_\_\_  
mm / dd / yyyy

Recovery End Date:

\_\_\_\_\_  
mm / dd / yyyy

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

(c) If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please provide the healthcare professional's name and contact information, as well as the nature of the treatments:

\_\_\_\_\_  
Name of Healthcare Provider (print clearly)

\_\_\_\_\_  
Type of Practice

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Email Address

Nature of Treatments:

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**PERFORMANCE OF JOB FUNCTIONS.** Complete this section to certify the employee's fitness to perform the essential functions of the job once s/he returns to work. Feel free to request of the employee or employer a list of the essential job functions.

7.

(a) If medical leave is required for the employee's absence from work due to the employee's own condition (including absence due to pregnancy or a chronic condition), once the employee returns to work, will the employee be unable to perform work of any kind?

Yes \_\_\_\_\_

No \_\_\_\_\_

(b) If the employee will be unable to perform all job functions, will the employee be unable to perform any one or more of the essential functions of the job? If yes, please list the essential job 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?

Yes \_\_\_\_\_

No \_\_\_\_\_

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**CARING FOR A FAMILY MEMBER.** Complete this section if requesting leave to care for a family member with a serious health condition.

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 needs, personal needs, safety, and/or transportation?

Yes \_\_\_\_\_

No \_\_\_\_\_

(b) If no, would the employee's presence to provide psychological comfort be beneficial to the patient and/or assist in the patient's recovery?

Yes \_\_\_\_\_

No \_\_\_\_\_

(c) If the patient will need care only intermittently or on a part-time basis, please indicate the date of the Qualifying Event (if applying for PFL), probable start date, and probable end date of this need:

Qualifying Event Date:  
(if applying for PFL)

\_\_\_\_\_  
mm / dd / yyyy

Intermittent/Part-Time Family Care Start Date:

\_\_\_\_\_  
mm / dd / yyyy

Intermittent/Part-Time Family Care End Date:

\_\_\_\_\_  
mm / dd / yyyy

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## ***Certification***

\_\_\_\_\_  
Name of Healthcare Provider (print clearly)

\_\_\_\_\_  
Type of Practice

\_\_\_\_\_  
Signature of Healthcare Provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Email Address