



**APPLICATION FOR EDUCATIONAL 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:
Primary Phone:			Alternate Phone:
Email Address:			
Date of Birth:			Last Four Digits of Social Security #: XXX-XX-
School or Department:			Position Title:
Supervisor:			

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

III. Educational Leave Request Information	
<p>In accordance with District of Columbia Municipal Regulations (DCMR) Chapter 12, § 1204; employees may request an Educational Leave of Absence for a total period of time not to exceed two (2) years.</p> <p>Employees who intend to take a two (2) year leave of absence, if approved, will receive approval for one year at a time, and must reapply for the second year of Educational Leave of Absence by March 1 of the first year of leave.</p>	
Name of University:	
Name of Degree Program:	
Program Start Date:	
Length of Program:	

I expect to return to duty on: \_\_\_\_\_

**I understand that I must give written notice by March 1 of the final year of my leave regarding whether or not I intend to return to employment within DCPS. Failure to give written notice shall be considered a voluntary resignation from the District of Columbia Public Schools.**

**I understand upon return, I may be placed in any position which by law, I am entitled to hold at the discretion of District of Columbia Public Schools.**

Full Name: (Print Clearly)	LAST FIRST MI	Employee ID Number:	
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**IV. Previous Leave Request Information**

Have you taken a leave of absence within the past two years?  YES  NO

If YES, please indicate the dates of leave: Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

If YES, please check the appropriate box indicating the type of leave that was used:

CHARTER SCHOOL  EDUCATIONAL  FAMILY CARE  MEDICAL  MILITARY

**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. I further understand that my benefits will automatically terminate if I am on leave for more than 365 days.

**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 DCPS Deputy Chief of Human Resources can approve Leave of Absence requests.** Your request is not approved until you receive an official letter from the DCPS Deputy Chief of Human Resources.

\_\_\_\_\_  
Immediate Supervisor/Principal Signature – Request for Approval \_\_\_\_\_  
Date

APPROVED  NOT APPROVED

\_\_\_\_\_  
Director of Human Resources Signature – Approval \_\_\_\_\_  
Date

APPROVED  NOT APPROVED

Full Name: (Print Clearly)	LAST FIRST MI	Employee ID Number:	
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**EMPLOYEE HEALTH BENEFITS OPTIONS WHILE IN NON-PAY STATUS**

**I. Personal Information**

Health Benefit Plan Name:		Health Benefit Plan Type:	Self Self +1 Family
Effective Leave Date:		Effective Return Date:	

**II. Benefits Information**

The US Office of Personnel Management and District Government have issued new regulations governing payments of health benefits premiums during non-pay status. These new regulations permit an employee to continue participation in the 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

\_\_\_\_\_  
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.