HOWARD UNIVERSITY EMPLOYEE REQUEST FOR DISTRICT OF COLUMBIA GOVERNMENT FAMILY/MEDICAL LEAVE

TO BE COMPLETED BY THE EMPLOYEE

1. <u>IDENTIFICATION INFORMATION</u>

Name		
(Last)	(First)	(Middle)
Social Security Number:		
Address/City/State/Zip Code:		
Daytime Telephone Number:		
Immediate Supervisor:		
Department Name		
Dept. Telephone Number:		
I hereby make application for leave Family and Medical Leave Act of 19 seq.), Chapter 16 of Title 4, District Instruction No. 12-16. (Check one): Family leave	e under the authority of the 990 (D.C. Law 8-181; D.	.C. Official Code § 32-501 et Regulations, and DPM
3. TO BE COMPLETED IF APP	LYING FOR FAMILY	LEAVE
A. I here by request family leave one the following purposes:	beginningand	ending for
The birth of my child (docu	mentation required).	
The placement of a child w (documentation required.)	ithin my home for adopti	on or foster care
The placement of a child wi parental responsibility (doct		I will charge and assume
To provide care for a family	- -	ous health condition

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	B.	(I understand that I may elect to use accrued annual leave, and/or compensatory time for family leave and, in so doing, any annual leave and/or compensatory time will count against my total 16-workweek entitlement to family leave.)			
	C.	If this application is to provide care for a family member, I understand that Medical certification of the serious health condition, issued by my family member's health care provider must be attached to this application.			
4.	<u>TO</u>	TO BE COMPLETED IF APPLYING FOR MEDICAL LEAVE			
	A.	I hereby request medical leave beginning and ending due to a serious health condition.			
	B.	(I understand that I may elect to used 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.)			
	C.	I understand that a medical certification of my "serious health condition," issued by my health care provider, must be attached to this application.			
5.		CONTINUATION OF HEALTH, (MEDICAL AND DEATH), AND LIFE			
	INSURANCE				
	Do you wish to continue your health and any group life insurance benefit for which you pay a premium during any unpaid period of your family medical leave entitlement?				
	Yes (I understand that I am responsible for continuing to pay my share of the health benefit and/or group life premium. If I do not pay during this period, I understand that the funds will be recovered through increased payroll deductions upon my return to duty.)				
		No. I understand that by canceling my health and/or group life insurance benefits ollment I cannot re-enroll in those programs until the earlier of (1) the next benefits en season," or (2) upon satisfying a benefits enrollment event.			

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6. **CERTIFICATION**

Signature		Date
Return documents to:		
	Elizabeth B. Banks Sr. Employee Relations Sp	ecialist
	Howard University Office of Talent Manageme	ent
	Department of Employee R	
	525 Bryant Street, N.W.	
	Suite 108	
	Washington, DC 20059	

FOR OFFICE USE ONLY - HOWARD UNIVERSITY O	FFICE OF EMPLOYEE RELATIONS & TEE
Approved	Disapproved
Signature of Approving Official	Date