Before you begin your application, to the extent possible, please ensure you have the required supporting documents completed and readily available for submission. A list of required documents is provided at the end of this application. Please print, scan, or take a clear photograph of the front and back of your completed documents and submit them as an attachment at the end of this application. Please note that you will not be able to submit your application if you do not have the required supporting documents.

|  |  |  |
| --- | --- | --- |
| **1. EMPLOYMENT INFO** |  | **2. PERSONAL INFO** |
| **Agency**  | **Last Name** | **Middle Name** | **First Name** |
| **Employee ID Number**  | **Street Address** | **Apt #** | **City** | **State** | **Zip**  |
|  | **Email Address** |
|  |  |
| **3. REASON FOR LEAVE REQUEST** |
| **a. Select one** **option.**[ ]  To care for myself[ ]  To provide care for a family member (non-military)[ ]  I require military family or caregiver leave |
| **b. If you selected military leave in (a), please specify the type of military leave you require.**[ ]  Exigency Military Leave[ ]  Military Caregiver Leave |
|  |
| **4. LEAVE DETAILS** |
| **a. What type of leave are you requesting? (Select all that apply.)**[ ]  Paid Family and Medical Leave (PFML)[ ]  DC FMLA[ ]  Federal FMLA | **b. Denote the number of hours that you wish to use for each leave program. Denote the hours of sick, annual, or other leave that you would like to use.**

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| --- | --- | --- | --- | --- |
| **PFML** |  | **Total FMLA (incl. PFML)** |  |  |
|  |  |  |  |  |
| **Annual** |  | **Sick** |  | **Other\_\_\_\_\_\_\_** |
|  |  |  |  |  |

 | **c. Estimate the beginning and end date of your leave period.**

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| --- | --- | --- |
| **Start Date** |  | **End Date** |
|  |  |  |

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| **5. REQUIRED SUPPORTING DOCUMENTS** |
| **CIRCUMSTANCE** | **MUST PROVIDE** |
| **Medical leave for a personal health condition** | Certificate of Health Care Provider for Employee’s Serious Health Condition ([DOH-WH-380-E](https://www.dol.gov/whd/forms/WH-380-E.pdf)) |
| **Caring for an ill family member (non-military)** | Certificate of Health Care Provider for Family Member’s Serious Health Condition ([DOL-WH-380-F](https://www.dol.gov/whd/forms/WH-380-F.pdf)); Reliable documentation establishing the familial relationship  |
| **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 |
| **Exigency Military Leave** | Certification of Qualifying Exigency for Military Family Leave ([DOL-WH-384](https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/WH-384.pdf)) |
| **Military Caregiver Leave (Caring for an ill family member who is a current service member or a veteran.)** | Certification of Serious Injury or Illness of Current Service member – Military Family Leave ([DOL-WH-385](https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/WH-385.pdf)) or Certification of Serious Injury or Illness of a Veteran for Military Caregiver Leave ([DOL-WH-385-V](https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/wh385V.pdf)) |
| **Miscarriage or Stillbirth**  | Certificate of Health Care Provider for Employee’s Serious Health Condition ([DOH-WH-380-E](https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/WH-380-E.pdf))  |

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| **6. EMPLOYEE CERTIFICATION** |
| **I certify that the information provided in this document is true and accurate and that I am eligible for the leave programs for which I have applied. In addition, I understand that the making of a false statement on this document is a violation of law and subject to criminal penalties. By signing this form, I certify that I understand and agree to all the terms described, and that I agree to have all notifications regarding my application and eligibility for leave programs sent to the email address provided on this form.**  |
|  |
| **Sign** | **Date** |

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| **7. AGENCY ACKNOWLEDGEMENT** |
| **Your agency FMLA Coordinator must sign below acknowledging your request for Family and Medical Leave. Their signature does not constitute an approval of this application. By signing below, your agency FMLA Coordinator agrees to send you notifications regarding your application and eligibility for leave programs using the email address provided below.** |
|  |
| **Sign** | **Date Email** |