**District Family and Medical Leave Coordinator**

***Via e-mail*** **dchr.fmla@dc.gov**

|  |  |
| --- | --- |
| **Re:** | **FAMILY AND MEDICAL LEAVE,** Choose an item. **– Approval Notification** |

To the District FMLA Coordinator:

This agency has approved a request for family or medical leave. **If this request includes Paid Family and Medical Leave (PFML), we are asking your office to forward the following information to the OPRS**:

|  |  |
| --- | --- |
| Employee | Click here to enter employee name. |
| Employee ID | **Click here to enter employee ID number.** |
| Agency | **Click here to enter employee’s agency.** |
| Program Designations  |[ ]  DC Family |[ ]  Federal FMLA |
|  | [ ]  | DC Medical |[ ]  Paid Family Medical Leave (PFL) |
| Date of Hire  | **Click here to enter date of hire.** |
| Qualifying Event Date | **Click here to enter date of qualifying event.** |
| First Date for Leave Usage | **Click here to enter date when leave will be first used by the employee.** |
| Leave Period | **Leave Start Date.** | to | **Leave End Date.** |

|  |
| --- |
|[ ]  Consecutive Weeks |
|[ ]  Intermittent Leave |
|[ ]  Reduced Schedule |

 |
| Hours Approved | **Click here to enter the total number of leave hours approved by the agency.** |

Please refer to page two of this communication if the employee will be on an intermittent leave schedule or a reduced leave schedule.

Sincerely,

|  |
| --- |
|  |
| Coordinator’s NameAgency FMLA Coordinator |

Cc Agency Head

Employee’s Immediate Supervisor

 Employee’s Timekeeper

 District FMLA Coordinator (*via* dchr.fmla@dc.gov)

**Approved Intermittent Leave**

If you have been approved for intermittent family and/or medical leave, please provide your approved intermittent schedule below:

[FIELDS ENTERED ARE PROVIDED AS EXAMPLES. CHANGE AS NEEDED, THEN DELETE THIS LINE]

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date(s) | 9/29/2015 | 9/29/15-10/1/15 | 9/29/15-10/1/15 |  |
| Time | 3:00-5:00 PM | 8:00 AM -5:00 PM | 3:00 – 5:00 PM |  |
| # of Hours | 2 | 24 | 6 |  |

**Approved Reduced Work Schedule**

If you have been approved for a reduced schedule for family and/or medical leave, please acknowledge that the following work schedule will meet your needs for the duration of your approved leave period:

[FIELDS ENTERED ARE PROVIDED AS EXAMPLES. CHANGE AS NEEDED, THEN DELETE THIS LINE]

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Sun | Mon | Tues | Wed | Thurs | Fri | Sat |
| Week 1 | 8:00-5:00 |  |  |  |  |  |  |
| Week 2 |  |  |  |  |  |  |  |

**Scheduling Unplanned Leave**

Should you need to deviate from the above schedule(s), please notify your FMLA Coordinator and immediate supervisor as soon as possible. If you believe your family or medical needs have changed, please contact your FMLA Coordinator.

**CONCURRENCE**

By signing below, I CERTIFY that the above date(s) have been reviewed and that I concur with the date(s) and time period of leave.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immediate Supervisor’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s Signature Date