GOVERNMENT OF THE DISTRICT OF COLUMBIA
D.C. Department of Human Resources

Request for Advance Leave or Leave Without Pay

TO: _____ **DATE**: _____

I, _____ an employee of the _____
(Organizational Unit)

within the _____, request an advance of _____ hours of
(Department or Agency)

leave to include the following:

_____ Hours of **Annual Leave** _____ Hours of **Sick Leave** _____ Hours of **Leave Without Pay (LWOP)**

The leave will begin on _____ and end on _____. The reason(s) for this request is/are:

_____

_____

EMPLOYEE ID NO. _____ **ORGANIZATIONAL CODE: _____**

❑ *Check here if a medical certificate from your physician is attached to the DCSF 1199 form. A medical certificate must be included if your request is for medical reasons.*

I understand that I am expected to return to duty on the first work day following the expiration of this leave or to notify my supervisor at least one (1) week before this leave request expires of the reason(s) why I am unable to return, and to specify the earliest date I shall return to work. **I UNDERSTAND THAT IF I FAIL TO DO EITHER OF THE ABOVE ACTIONS, I MAY BE PLACED IN AN ABSENCE WITHOUT LEAVE (AWOL) STATUS. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING MY SHARE OF THE HEALTH BEENFITS CONTRIBUTION DURING THE TIME I AM ON LEAVE WITHOUT PAY, OR THERE IS INSUFFICIENCY SALARY TO COVER MY HEALTH BENEFITS CONTRIBUTION.**

_____
(Employee Signature)

EMPLOYMENT RECORD INFORMATION

Title of Position: _____ EOD Date (w/Department/Agency): _____

Series and Grade: _____ Health Benefits Code: _____

Present Leave Balance: Annual Leave _____ Sick Leave _____

Leave Used (Current Year): Annual Leave _____ Sick Leave _____ LWOP _____ AWOL _____

Previous Leave advances (Current Year): Annual Leave _____ Sick Leave _____ LWOP _____

Total Service: District Government: **Years:** _____ **Months**: _____ Federal Government: _____ **Years:** ____ **Months**: _____

_____
Signature of HR Advisor or Time and Attendance Representative

(Over)

RECOMMENDATION – SUPERVISOR

Recommendation of Supervisor:

❑ APPROVE ❑ DISAPPROVE Dates: From _____ to _____

_____
Signature of Supervisor

FINAL DETERMINATION – AGENCY HEAD

Final Determination:

❑ APPROVED ❑ DISAPPROVED Dates: From _____ to _____

_____
Signature of Agency Head (or Designee)

Distribution: **Original** – Employing Agency; **Copy** – Employee; **Copy** – OPF; **Copy** – OPRS; **Copy** – DCHR Benefits