

Request for Leave or Approved Absence

1. Name (Last, first, middle)	2. Employee or Social Security Number
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3. Organization

4. Type of Leave/Absence						5. Family and Medical Leave
Check appropriate box(es) and enter date and time below)	Date		Time		Total Hours	If annual leave, sick leave, or leave without pay will be used under the Family and Medical Leave Act of 1993 (FMLA), please provide the following information:
	From	To	From	To		
<input type="checkbox"/> Accrued annual leave						<input type="checkbox"/> I hereby invoke my entitlement to family and medical leave for: <input type="checkbox"/> Birth/Adoption/Foster care <input type="checkbox"/> Serious health condition of spouse, son, daughter, or parent <input type="checkbox"/> Serious health condition of self <i>Contact your supervisor and/or your personnel office to obtain additional information about your entitlements and responsibilities under the FMLA. Medical certification of a serious health condition may be required by your agency.</i>
<input type="checkbox"/> Restored annual leave						
<input type="checkbox"/> Advance annual leave						
<input type="checkbox"/> Accrued sick leave						
<input type="checkbox"/> Advance sick leave						
Purpose: <input type="checkbox"/> Illness/injury/incapacitation of requesting employee <input type="checkbox"/> Medical/dental/optical examination of requesting employee <input type="checkbox"/> Care of family member, including medical/dental/optical examination of family member, or bereavement <input type="checkbox"/> Care of family member with a serious health condition <input type="checkbox"/> Other						
<input type="checkbox"/> Compensatory time off						
<input type="checkbox"/> Other paid absence (specify in remarks)						
<input type="checkbox"/> Leave without pay						

6. Remarks

7. Certification: I certify that the leave/absence requested above is for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification of information on this form may be grounds for disciplinary action, including removal.

7a. Employee signature	7b. Date signed
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8a. Official action on request Approved Disapproved *(If disapproved, give reason. If annual leave, initiate action to reschedule.)*

8b. Reason for disapproval

8c. Signature	8d. Date signed
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Privacy Act Statement
 Section 6311 of title 5, United States Code, authorizes collection of this information. The primary use of this information is by management and your payroll office to approve and record your use of leave. Additional disclosures of the information may be: To the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to a State unemployment compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the Office of Personnel Management or the General Accounting Office when the information is required for evaluation of leave administration; or the General Services Administration in connection with its responsibilities for records management.

Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal Government furnish a social security number or tax identification number. This is an amendment to title 31, Section 7701. Furnishing the social security number, as well as other data, is voluntary, but failure to do so may delay or prevent action on the application. If your agency uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.

INFORMATION PERTAINING TO JURY SERVICE

1. Name of employee: _____

2. Reported for jury service: _____
Date/Hour

3. Discharged from jury service: _____
Date/Hour

4. Interim periods excused from service (please list if appropriate):

Date/Hour

Date/Hour

5. Reimbursement (per day):

Jury fee: _____

Witness fee: _____

Expenses: _____

6. Name of Court: _____

(Signature/Date)

NOTE TO COURT OFFICIAL: The Department of the Navy is requesting the above information to ensure that it complies with the provisions of Title 5 U.S. Code 5515.

NOTE TO EMPLOYEE: In cases where an employee is excused from jury duty for a substantial part of a workday, the employee is expected to return to duty or request annual leave or leave without pay for the balance of the tour of duty (unless this would result in a hardship). You should contact your supervisor or team leader for instructions in such a situation.

Application to Become a Leave Recipient Under the Voluntary Leave Transfer Program

1. Applicant's name (Last, first, middle)		2. Social Security Number	3. Employee Number
4a. Position title	4b. Pay plan	4c. Grade/pay level	
5. Name of organization (Agency, Department, Office, Division, Branch, etc.)		6. Office telephone number	
7. Nature and severity of the medical emergency			
8. Individual affected by medical emergency (check one) <input type="checkbox"/> Employee <input type="checkbox"/> Employee's family member	9. Date medical emergency began	10. Date medical emergency ended (or is expected to end)	
11. Name of physician who will verify the medical emergency. (Attach documentation from the physician (or other appropriate expert) showing the diagnosis, prognosis and duration of illness.)			
12. What is the applicant's annual and sick leave balances as of end of last pay period? Annual leave balance → <input style="width: 50px; height: 20px;" type="text"/> Sick leave balance → <input style="width: 50px; height: 20px;" type="text"/>		13. How many hours of leave without pay have been used for this medical emergency? Hours → <input style="width: 50px; height: 20px;" type="text"/>	
14. Provide a description of the medical emergency to be distributed to servicing personnel offices so that other employees may donate annual leave to the applicant. <input type="checkbox"/> Check box if applicant does not want a description distributed. <input type="checkbox"/> Check box if applicant does not wish to have name used with the description or disclosed to anyone except the supervisor, the supervisory channel and the deciding official, and individuals who maintain the program.		Description of medical emergency	
15a. Name of individual completing application (If applying on behalf of the applicant)	15b. Relationship to applicant	15c. Telephone number (area code)	
16a. I certify that the above statements are true. (Signature of applicant or individual applying on behalf of applicant)		16b. Date signed	
<p>Privacy Act Statement</p> <p>Participation in this program is voluntary; however, solicitation of this information is authorized under 5 U.S.C. 6332. The information furnished will be used to identify records properly associated with the transfer of annual leave. It may also be disclosed to a national, State, or local law enforcement agency where there is an indication of a violation or potential violation of civil or criminal law, rule, or regulation; or to another agency or court when the Government is party to a suit. Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal Government furnish a social security number or tax identification number. This is an amendment to title 31, Section 7701. Furnishing the social security number, as well as other data, is voluntary, but failure to do so may delay or prevent action on the application. If your agency uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.</p>			
17. First level supervisor's recommendation <input type="checkbox"/> Approve <input type="checkbox"/> Disapprove Signature _____ Date signed _____		18. Deciding official's decision <input type="checkbox"/> Approve <input type="checkbox"/> Disapprove Signature _____ Date signed _____	

**Request to Donate Annual Leave to Leave Recipient
Under the Voluntary Leave Transfer Program**

*Within
Agency*

I request that annual leave be transferred to the leave account of an approved leave recipient. This recipient is not my immediate supervisor. As of the date indicated below, I have enough annual leave in my account to cover this amount. I understand that if I am projected to forfeit annual leave during this leave year, the amount of leave I am transferring may not exceed the number of hours remaining in the leave year for which I am scheduled to work. The amount of annual leave I am transferring also is not more than half the hours I will earn this year.

I understand that my decision to transfer leave is not revocable. If a sufficient balance of unused leave remains after the recipient's medical emergency has terminated, I can elect to have a pro-rated share returned to me during either the current leave year or the following leave year, or I can elect to donate my pro-rated share to another leave recipient. However, to do so, I must remain employed by a Federal agency and be subject to chapter 63 of title 5, United States Code.

I have not been directly or indirectly intimidated, threatened or coerced, or promised any benefit by any employee for the purpose of donating or using leave.

To Be Completed By Leave Donor

1. Name (Last, first, middle)		2. Social Security Number	3. Employee Number
4a. Position title		4b. Pay plan	4c. Grade/pay level
5a. Name of organization (Agency, Department, Office, Division, Branch, etc.)			5b. Office telephone number
6. Amount of annual leave accrued as of end of last pay period	7. Amount of leave projected to forfeit this leave year as of end of last pay period	8. Amount of annual leave to be transferred	
9. Individual's name or identification number to whom leave is being donated			
10a. Signature			10b. Date signed

Privacy Act Statement

Participation in this program is voluntary; however, solicitation of this information is authorized under 5 U.S.C 6332. The information furnished will be used to identify records properly associated with the transfer of annual leave. It may also be disclosed to a national, State, or local law enforcement agency where there is an indication of a violation or potential violation of civil or criminal law, rule, or regulation; or to another agency or court when the Government is party to a suit. Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal Government furnish a social security number or tax identification number. This is an amendment to title 31, Section 7701. Furnishing the social security number, as well as other data, is voluntary, but failure to do so may delay or prevent action on the application. If your agency uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.

MEMORANDUM

From:

To:

Subj: VOLUNTARY LEAVE TRANSFER PROGRAM APPLICATION FOR
LEAVE TRANSFER

1. ____ Based on your medical emergency, your request to participate in the Voluntary Leave Transfer Program (VLTP) has been approved. Other employees may request to transfer annual leave to your leave account. You or your personal representative must provide medical documentation on a monthly basis to support the qualifying medical emergency (unless determined otherwise). The medical emergency will terminate when one of the following occurs:
 - a. your Federal service terminates;
 - b. at the end of the biweekly pay period in which you or your personal representative provides written notice that you are no longer affected by the medical emergency;
 - c. at the end of the pay period in which management is notified that the Office of Personnel Management has approved an application for disability retirement; or
 - d. at the end of the pay period in which management determines, after providing you written notice and an opportunity to respond orally, that you are no longer affected by a medical emergency.
2. ____ Your application has been disapproved for the following reason(s):
3. You may grieve the decision to disapprove your application. The grievance procedure has time frames within which your grievance must be filed.
4. If you have additional questions, please contact _____ at xxx-xxxx.

MEMORANDUM

From:

To:

Subj: DISPOSITION OF LEAVE DONOR APPLICATION

1. Upon receipt, payroll will transfer _____ hours of annual leave from your account to the account of your designated recipient. If the leave recipient's medical emergency terminates while a balance of transferred leave remains, the remaining leave will be pro-rated and returned to the donor. Payroll will contact you in writing if such a situation should occur.

2. Please contact _____ at xxx-xxxx, if you have additional questions.

Copy to:

HRO

11 Dec 01

Request to Donate Annual Leave to Leave Recipient Under the Voluntary Leave Transfer Program

*Outside
Agency*

I request that annual leave be transferred to the leave account of an approved leave recipient. This recipient is not my immediate supervisor. As of the date indicated below, I have enough annual leave in my account to cover this amount. I understand that if I am projected to forfeit annual leave during this leave year, the amount of leave I am transferring may not exceed the number of hours remaining in the leave year for which I am scheduled to work. The amount of annual leave I am transferring also is not more than half the hours I will earn this year.

I understand that my decision to transfer leave is not revocable. If a sufficient balance of unused donated leave remains after the recipient's medical emergency has terminated, I can elect to have a pro-rated share returned to me during either the current leave year or the following leave year, or I can elect to donate my pro-rated share to another leave recipient. However, to do so, I must remain employed by a Federal agency and be subject to chapter 63 of title 5, United States Code. I have not been directly or indirectly intimidated, threatened or coerced, or promised any benefit by any employee for the purpose of donating or using leave.

Part A - To Be Completed By Leave Donor

1. Name (Last, first, middle)		2. Social Security Number		3. Employee Number	
4a. Position title	4b. Pay plan	4c. Grade/pay level	5. Relationship of leave donor to leave recipient (if any)		
6. Leave donor's agency (Agency, Department, Office, Division, Branch, etc.)					
7. Amount of annual leave accrued as of end of last pay period		8. Amount of leave projected to forfeit this leave year as of end of last pay period		9. Amount of annual leave to be transferred	
10. Leave recipient's name, agency, agency's address, organization (Agency, Department, Office, Division, Branch, etc.)					
11a. Leave donor's signature				11b. Date signed	

Privacy Act Statement

Participation in this program is voluntary; however, solicitation of this information is authorized under 5 U.S.C 6332. The information furnished will be used to identify records properly associated with the transfer of annual leave. It may also be disclosed to a national, State, or local law enforcement agency where there is an indication of a violation or potential violation of civil or criminal law, rule, or regulation; or to another agency or court when the Government is party to a suit. Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal Government furnish a social security number or tax identification number. This is an amendment to title 31, Section 7701. Furnishing the social security number, as well as other data, is voluntary, but failure to do so may delay or prevent action on the application. If your agency uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.

Part B - To Be Completed By Employing Agency of Leave Donor

Upon completion and approval of this form, forward a copy to the leave recipient's employing agency as soon as possible so that the transfer of leave can take place.	
12. Enter the amount of annual leave to be credited to the leave recipient's annual leave account	13. If the agency is waiving the maximum limitations for leave donation under the voluntary leave transfer program, describe the special circumstance that warrants the waiver
14a. Name of agency contact who can provide further information	14b. Telephone number
15. Certification: I certify that the leave donor currently has sufficient annual leave in his/her annual leave account to make a donation of the requested amount of annual leave and that the amount of the donation does not exceed the maximum limitations for leave donation under the voluntary leave transfer program.	
15a. Signature of authorizing official	15b. Date Signed