SF 71
(Revised 3/79)
OFFICE OF PERSONNEL MANAGEMENT
FPM Supple. 990-2, & 2-9

APPLICATION FOR LEAVE

INSTRUCTIONS: Please complete Items 1-8 after reading the Privacy Act Statement shown below.

1. Name *(Print or type -- Last, First, M.I.)*			**2. Employee I.D. Number**	
3. Organizational Unit	**4-A** **MONTH** **FROM:**	**DAY**	**Hour** **A.M.** **P.M.**	**4-C Total Number of Hours**
5. I hereby request *(If more than one box is checked, explain in Item 6, Remarks):*	**4-B** **MONTH** **TO:**	**DAY**	**Hour** **A.M.** **P.M.**	
☐ **Annual Leave** *(Annual leave requested may not exceed the amount available for use during the leave year.)*	**6. Remarks**			
☐ **Sick Leave.** *(Complete reverse side of form.)*				
☐ **Leave Without Pay.**				
☐ **Compensatory Time.**	**7. Employee's Signature**			**8. Date** *(Month, Day, Year)*
☐ **Other.** *(Specify)*				

OFFICIAL ACTION ON APPLICATION

☐ **Approved** ☐ **Disapproved** *(If disapproved, give reason. If annual leave, initiate action to reschedule.)*	**Signature** *(Annual leave approved may not exceed the amount available for use during the leave year.)*	**Date** *(Month, Day, Year)*

NSN 7540-00-753-5067

Please detach this notice before submitting SF 71.

PRIVACY ACT STATEMENT

Section 6311 of Title 5 to the U.S. 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 on you for employment or security reasons; to the Office of Personnel Management or General Accounting Office when the information is required for

 (Continue on Reverse)

EMPLOYEE -- Check the appropriate box below (Items 1-4) if you are applying for sick leave. If your agency requires such certification, please have your doctor or practitioner complete the Certification section below. Falsification of information in this portion of the form may be grounds for disciplinary action, including dismissal.

1. I was incapacitated for duty by:

☐ **Sickness.** ☐ **Off-The-Job Injury.**

☐ **On-The-Job Injury.** ☐ **Pregnancy and Confinement.**

2. I was required to care for a member of my family with a contagious disease. *(Give name and relationship of family member, and name of disease.)* ☐

3. I will be undergoing medical, dental, or optical examination or treatment ☐

4. I was exposed to a contagious disease. *(Give name of disease and circumstances of exposure.)* ☐

CERTIFICATION OF PHYSICIAN OR PRACTITIONER

Employee's Name

Period Under Professional Care *(Indicate Month, Day, Year)*

From: **To:**

Remarks

I certify that the employee named was under my professional care for the period indicated above, and that the employee's condition during this period made reporting to work inadvisable.

Signature of Physician or Practitioner

Date *(Month, Day, Year)*

evaluation of leave administration; and to the General Services Administration in connection with its responsibilities for records management.

Where the employee identification number is your Social Security Number, collection of this information is authorized by Executive Order 9397. Furnishing the information on this form, including your Social Security Number, is voluntary, but failure to do so may result in disapproval of this request.

If your agency uses the information furnished on this form for purposes other than these indicated above, it may provide you with an additional statement reflecting those purposes.