VOLUNTARY LEAVE TRANSFER PROGRAM **LEAVE RECIPIENT APPLICATION**	**1. PAYBLOCK NUMBER**

PRIVACY ACT STATEMENT

AUTHORITY: EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSE(S): Individuals wishing to participate in the Voluntary Leave Transfer Program as recipients of leave make application by completing this form. The information provided is used to validate the applicant's request.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure to provide requested information may impede the validation process.

2. EMPLOYEE IDENTIFICATION

a. NAME *(Last, First, Middle Initial)*	b. SOCIAL SECURITY NO.
c. POSITION TITLE	d. GRADE/STEP
e. ORGANIZATION	f. SALARY

3. LEAVE DATA

a. AS OF *(YYMMDD)*	b. ANNUAL LEAVE BALANCE	c. SICK LEAVE BALANCE	d. DATE AVAILABLE LEAVE EXPIRES *(YYMMDD)*	e. ACCRUAL RATE FOR ANNUAL LEAVE

4. MEDICAL EMERGENCY

a. DESCRIPTION *(Attach appropriate documentation)*

b. EXPECTED DURATION	c. APPROXIMATE FREQUENCY *(If recurring)*

5. CONTACT DURING PERIOD OF EMERGENCY

a. EMPLOYEE TELEPHONE NUMBER *(If available)* *(Include Area Code)*	b. OTHER POINT OF CONTACT *(If applicable)*	
	(1) Name *(Last, First, Middle Initial)*	(3) Address *(Street, City, State and Zip Code)*
	(2) Telephone Number *(Include Area Code)*	

6. EMPLOYEE CERTIFICATION

I am aware that publication of all or part of the above information may be necessary to find leave donors.

a. SIGNATURE	b. DATE SIGNED *(YYMMDD)*

7. SUPERVISOR APPROVAL

a. SIGNATURE	b. DATE SIGNED *(YYMMDD)*