REQUEST FOR LEAVE OR APPROVED ABSENCE

1. NAME (Last, First, Middle Initial)				2. EMPLOYEE OR SOCIAL SECURITY NUMBER		
3. ORGANIZATION						
4. TYPE OF LEAVE/ABSENCE (Check appropriate box(es) below.)	Prom: To:		TIME From: To:		TOTAL HOURS	5. FAMILY AND MEDICAL LEAVE
Accrued Annual Leave						If annual leave, sick leave, or leave without pay will be used under the Family and Medical
Restored Annual Leave		<u> </u>				leave Act of 1993, please provide the following information:
Advanced Annual Leave	<u> </u>	<u> </u>	<u> </u>		<u> </u>	I hereby invoke my entitlement to Family and Medical Leave for:
Accrued Sick Leave		<u> </u>	<u> </u>			Birth/Adoption/Foster Care
Advanced Sick Leave						Serious Health Condition of Spouse, Son, Daughter, or Parent
Purpose: Medical/dental/optical examination of requesting employee Other Serious Health Condition of Self Care of family member/bereavement, including medical/dental/optical						
examination of family member	T	T	<u></u>			Contact your supervisor and/or your personnel office to
Compensatory Time Off		<u> </u>				obtain additional information about your entitlements and responsibilities under the Family and Medical
Other Paid Absence (Specify in Remarks)						Leave Act of 1993.
Leave Without Pay]
6. REMARKS						
purpose(s) indicated. I understand that I	must coml	lv with mv	employing	agency's pr	rocedures for r	ertify that such leave/absence is requested for the requesting leave/approved absence (and provide tion on this form may be grounds for disciplinary
EMPLOYEE SIGNATURE DATE						
8. OFFICIAL ACTION ON REQUEST: (If disapproved, give reason. If annual	· · · · · · · · · · · · · · · · · · ·	PPROVED ate action to		ISAPPROV .)	'ED	
SIGNATURE DATE						
		PRIVA	ACY ACT S	STATEME	NT	
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 ciminal 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.

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

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.