

Request for Leave or Approved Absence

1. Name <i>(Last, first, middle)</i>	2. Organization
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3. Type of Leave/Absence					4. Family and Medical Leave	
Check appropriate box(es) and enter date(s) and time(s) below:	Date		Time		Total Hours	
	From	To	From	To		
<input type="checkbox"/> Accrued annual leave						If LWOP will be used under the Family and Medical Leave Act of 1993 (FMLA), please provide the following information <input type="checkbox"/> I hereby invoke my entitlement to use family and medical leave for: <input type="checkbox"/> Birth/Adoption/Foster Care <input type="checkbox"/> Serious health condition of spouse, son, daughter or parents <input type="checkbox"/> Serious health condition of self Contact your supervisor and/or your HR office to obtain additional information about your entitlements and responsibilities under the FMLA. Medical certification, including duration shall be attached.
<input type="checkbox"/> Accrued 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"/> Disabled Veteran Leave						
<input type="checkbox"/> I am self certifying that this medical leave qualifies under the Disabled Veteran Leave Act. <i>(Applies to Veterans with a 30% or more disability, who were hired on or after November 5, 2016)</i>						
<input type="checkbox"/> Compensatory time off						
<input type="checkbox"/> Other paid absence <i>(specify in remarks)</i>						
<input type="checkbox"/> Leave without pay						

5. Remarks

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

7a. Employee Signature	7b. Date Signed
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8a. Official Action on Request Approved Disapproved

8b. Manager Signature	8c. 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.