LEAVE TRANSFER PROGRAM - RECIPIENT APPLICATION

FOR PERSONNEL USE ONLY:
CASE NUMBER

INSTRUCTIONS for MRP Employees: Use this form to apply to be a leave recipient under Public Law 100-566. Attach to this form a brief description of the nature and severity of the medical emergency and appropriate documentation of the medical emergency: a physician's certificate, the medical prognosis and anticipated duration of the condition. After completing this form, forward through your supervisor to the office in your agency designated to approve leave recipients. **Approval as a leave recipient does not guarantee that leave will be donated. Donor employees will designate the recipient of their leave.**

PART I - APPLICATION AND CERTIFICATION *(To be completed by the applicant or another employee on his or her behalf)*

1. NAME *(Last, First, Middle Initial)*		2. POSITION TITLE		3. SOCIAL SECURITY NUMBER *(Last four)*
4. SERIES, GRADE OR PAY LEVEL	5. DUTY STATION	6. ORGANIZATIONAL TITLE *(Agency, Division, Branch, Section)*		
7. OFFICE ADDRESS		8. OFFICE TELEPHONE NO.		9. HOME TELEPHONE NO.
10. NAME OF TIMEKEEPER	11. TELEPHONE NO. OF TIMEKEEPER	12. OFFICE ADDRESS OF TIMEKEEPER		
13. T&A CONTACT POINT NO.	14. ANTICIPATED OR ACTUAL DURATION OF MEDICAL EMERGENCY *(if known)*		15. DATES LEAVE EXHAUSTED	16. AMOUNT OF DONATED LEAVE REQUESTED *(hours, days or months)*
	Beginning Date:	Ending Date:	Annual:	Sick *(if applicable):*

17. PLEASE INDICATE HOW YOU PREFER THE ANNUAL LEAVE DONATED TO BE APPLIED BY NUMBERING THE FOLLOWING IN ORDER OF YOUR PREFERENCE. (Donated annual leave may be applied to retroactively replace leave without pay and / or advanced sick or annual leave in connection with this medical emergency.)

PLEASE INDICATE PAY PERIODS DONATED ANNUAL LEAVE MAY BE RETROACTIVELY APPLIED

____ For current use ____ against advanced annual leave ____ against advanced sick leave ____ against LWOP

18. I agree to have my name and program published for the purpose of receiving donations. ☐ Yes ☐ No

CERTIFICATION *(If certifying on behalf of another employee, modify as appropriate.)*

I certify that (1) I have been affected by the medical emergency described in the attachment since the date indicated above, (2) I have or will have exhausted all annual leave and any available sick leave that could otherwise be used as of date indicated above, and (3) I expect to be absent from duty without paid leave at least 24 hours because of this medical emergency. I further certify that I am not receiving unemployment benefits or workers' compensation benefits in connection with this medical emergency for which I am requesting transferred annual leave.

SIGNATURE OF RECIPIENT OR HIS OR HER DESIGNEE *(please specify):* ☐ Recipient ☐ Designee				DATE
CONCURRENCE: ☐ Yes ☐ No	SIGNATURE OF SUPERVISOR	TITLE	OFFICE TELEPHONE NO.	DATE

PART II- AGENCY REVIEW AND APPROVAL

1. CURRENT ANNUAL LEAVE BALANCE *(in hours)*	2. CURRENT SICK LEAVE BALANCE *(in hours)*	3. LWOP HOURS USED IN CONJUNCTION WITH THIS EMERGENCY	4. ADVANCED SICK LEAVE HOURS TO DATE	5. ADVANCED ANNUAL LEAVE HOURS TO DATE	6. ANNUAL LEAVE CATEGORY PER PAY PERIOD

APPLICATION APPROVED:

☐ Yes *(If Yes, transferred leave may be credited to the recipient's account effective Pay Period Number):* _____

☐ No *(state reason for disapproval):*

SIGNATURE OF APPROVING OR DISAPPROVING OFFICIAL	TITLE	OFFICE TELEPHONE NO.	DATE

PRIVACY ACT STATEMENT

5 U.S.C. 6311 authorizes collection of this information. Your social security number may be disclosed to leave donors for the purpose of positively identifying leave recipients so that donated leave can be credited to the proper account.

Clear Form

AD-1046
Previous edition unusable (Rev. 4/89)