LEAVE RECIPIENT REQUEST

PRIVACY ACT STATEMENT
(5 USC 6311 AND 5 CRF 630)

Social Security Number and other data provided will be used in the operation of the Annual Leave Transfer Program to verify balances and make appropriate leave transactions. Disclosure is mandatory. Failure to provide required information will result in non-acceptance of application for leave transfer program participation.

TO ☐ ***CESPD-HR-SF*** ☐ ***CESPD-HR-SK*** ☐ ***CESPD-HR-LA***	FROM *(Last, First, MI)*	DATE
SOCIAL SECURITY NUMBER	JOB TITLE	SERIES, GRADE, STEP
PAY *(Per Annum/Hourly)*	ORGANIZATION *(Division/District, Branch)*	PHONE NUMBER

BALANCE OF ANNUAL LEAVE NUMBER OF HOURS _____ AS OF _____ *(Date)*	BALANCE OF SICK LEAVE NUMBER OF HOURS _____ AS OF _____ *(Date)*

CHECK THE APPROPRIATE CATEGORY OF YOUR ANNUAL LEAVE ACCRUAL

☐ 4 HOURS A PAY PERIOD ☐ 6 HOURS A PAY PERIOD ☐ 8 HOURS A PAY PERIOD

HAS A REQUEST FOR ADVANCED ANNUAL OR SICK LEAVE BEEN INITIATED? ☐ YES ☐ NO

IF YES, _____ HOURS OF ☐ SICK ☐ ANNUAL LEAVE HAS BEEN REQUESTED.

I understand that to become a candidate for the leave program, medical or other documentation is required to validate the reason(s) and that the duration of absence from duty is at least 24 hours. I understand that all of my available leave must be depleted before any transfer of leave donations can occur. I have attached the required documentation to verify my personal emergency. The following briefly describes the nature, severity, and anticipated duration of the medical, family, or other hardship situation I am currently experiencing:

_____
(Signature)

CESPD FORM P032-R
1 OCT 96

(Previous edition is obsolete)