

APPLICATION TO BECOME A LEAVE RECIPIENT

Proponent - DRM: Directive - FLW CPR 690-12

In accordance with the Voluntary Leave Transfer Program, I request to be a leave recipient under the program. The following information is provided:

Name: [ ] Employing Activity: [ ]
Position Title, Grade and Step: [ ] Duty Phone: [ ]

DETAILED AND SPECIFIC DESCRIPTION of the nature of the medical emergency, including medical documentation, if appropriate:

[ ]

Date Personal Emergency Began (If surgery, state date of surgery): [ ]
Anticipated Duration: [ ]
If recurring, the approximate frequency of the medical emergency: [ ]

Annual leave balance [ ] hours as of [ ] Sick leave balance [ ] hours as of [ ]

Copy of latest DA Form 4536, Earnings and Leave Statement (or MyPay printout) must be attached.

I have [ ] I have not [ ] requested advanced sick leave.
I do [ ] I do not [ ] grant permission to notify the workforce of my need for leave donations.
I do [ ] I do not [ ] grant permission to notify the workforce of the reason for my need of donations.

SUPERVISORY COORDINATION AND RECOMMENDED ACTION

Name and Title [ ] [ ] Approve [ ] Disapprove
Name and Title [ ] [ ] Approve [ ] Disapprove
Name and Title [ ] [ ] Approve [ ] Disapprove

APPROVING OFFICIAL

Name and Title [ ] Date [ ] [ ] Approve [ ] Disapprove

If form is not completely filled out, it will be returned without action for applicant.