



Request for Leave or Approved Absence

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|--|------|----|------|----------|----------------|
| 1. Name | | | | | |
| 2. Type of Leave/Absence (Check appropriate box(es) below) | Date | | Time | | Total Hours |
| | From | To | From | To | |
| Accrued Annual Leave | | | | | |
| Restored Annual Leave | | | | | |
| <input type="checkbox"/> Advanced Annual Leave | | | | | |
| Accrued Sick Leave | | | | | |
| Advanced 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 <input type="checkbox"/> Care of family member with a serious health condition <input type="checkbox"/> Other | | | | | |
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| | | | | | |
| <input type="checkbox"/> Bereavement | | | | | |
| <input type="checkbox"/> Other Paid Absence (Specify in Remarks) | | | | | |
| <input type="checkbox"/> Leave Without Pay | | | | | |
| Comp Time Used | | | | | |
| 3. Family and Medical Leave | | | | | |
| If annual leave, sick leave, or leave without pay will be used under the Family and Medical Leave Act of 1993, please provide the following information: <input type="checkbox"/> I hereby invoke my entitlement to Family and Medical Leave for: Birth/Adoption/Foster Care Serious health condition of family member <input type="checkbox"/> Serious health condition of self Contact your supervisor and/or your personnel office to obtain additional information about your entitlements and responsibilities under the Family and Medical Leave Act. Medical certification of a serious health condition may be required by your agency. NOTE: IF REQUESTING PAID PARENTAL LEAVE, PLEASE COMPLETE THE PAID PARENTAL LEAVE REQUEST FORM FOUND IN BOX. | | | | | |
| 4. Certification: I hereby request leave/approved absence from duty as indicated above and certify that such leave/absence is requested for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/ approved absence (and provide additional documentation, including medical certification, if required) and that falsification on this form may be grounds for disciplinary action, including removal. | | | | | |
| 4a. Employee Signature | | | | 4b. Date | |
| Carolyn Kaneko | | | | | |
| 4c. Supervisor Signature of Approval | | | | 4d. Date | |
| Caroline Broder | | | | 9/27/24 | |
| REMARKS: | | | | | |
| 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. | | | | | |