

APPLICATION FOR LEAVE

INSTRUCTIONS: Please complete Items 1-8 after reading the Privacy Act Statement shown below

1. Name (Print or type--Last, First, M.I.)			2. Employee I.D. Number - -		
3. Organizational Unit	4-A Month	Day	Hour	A.M.	4-C Total Number of Hours
	FROM:			P.M.	
5. I hereby request (If more than one box is checked, explain in Item 6, Remarks.) <input type="checkbox"/> Annual Leave (Annual Leave requested may not exceed the amount available for use during the leave year) <input type="checkbox"/> Sick Leave (Complete reverse side of form) <input type="checkbox"/> Leave Without Pay <input type="checkbox"/> Compensatory Time <input type="checkbox"/> Other (Specify)	4-B Month	Day	Hour	A.M.	
	TO:			P.M.	
6. Remarks					
7. Employee's Signature					8. Date (Month, Day, Year)

OFFICIAL ACTION ON APPLICATION

<input type="checkbox"/> Approved	<input type="checkbox"/> Disapproved (If disapproved, give reason. If annual leave, initiate action to reschedule.)	Signature (annual leave approved may not exceed the amount available for use during the leave year)	Date (Month, Day, Year)
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NSN 7540-00-753-5067

EMPLOYEE -- Check the appropriate box below (Items 1-4) if you are applying for sick leave. If your agency requires such certification, please have your doctor or practitioner complete the Certification section below. Falsification of information in this portion of the form may be grounds for disciplinary action, including dismissal.

1. I was incapacitated for duty by: <input type="checkbox"/> Sickness <input type="checkbox"/> On-The-Job Injury <input type="checkbox"/> Off-The-Job Injury <input type="checkbox"/> Pregnancy and Confinement	2. I was required to care for a member of my family with a contagious disease. (Give name and relationship of family member, and name of disease.) <input type="checkbox"/>
3. I will be undergoing medical, dental, or optical examination or treatment <input type="checkbox"/>	4. I was exposed to a contagious disease. (Give name of disease and circumstances of exposure.) <input type="checkbox"/>

CERTIFICATION OF PHYSICIAN OR PRACTITIONER

Employee's Name	Period Under Professional Care (Indicate Month, Day, Year)
Remarks	From: To:
I certify that the employee was under my professional care for the period indicated above, and that the employee's condition during this period made reporting to work inadvisable.	
Signature of Physician or Practitioner	Date (Month, Day, Year)

Please detach this notice before submitting SF 71

PRIVACY ACT STATEMENT

Section 6311 of Title 5 to the U.S. 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 ; to a State Unemployment compensation office regarding a claim; to Federal Life Insurance of 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 on you for employment or security reasons; to the Office of Personnel Management or General Accounting Office when the information is required for evaluation of leave administration; and to the General Services Administration in connection with its responsibilities for records management.

Where the employee identification number is your Social Security Number, collection of this information is authorized by Executive Order 9937. Furnishing the information on this form, including your Social Security Number, is voluntary, but failure to do so may result in disapproval of this request.

If your agency uses the information furnished on this form for purposes other than these indicated above, it may provide you with an additional statement reflecting those purposes.