

**VOLUNTARY LEAVE TRANSFER AND BANK RECIPIENT APPLICATION**

1. Applicant's Name		2. Social Security Number	
3. Position Title		4. Position Grade/Step	
5. Home Address and Telephone Number			
6. Employing Agency		7. Time Keeper:  Telephone Number:	
8. Immediate Supervisor's Name/Title/Address			
9. I understand that I may participate in both the Voluntary Leave Transfer and the Voluntary Leave Bank program at the same time for the same medical emergency. Please submit my request to the following program. (Check appropriate box)  [ ] VLTP      [ ] VLBP      [ ] Both			
10. If approved as a recipient under the VLTP, I do/do not (check appropriate box) authorize the release of information contained on this form or supporting documents by the VLTP committee to publicize my need for leave to potential donors.  [ ] I do authorized the release of information to publicize my need for leave. [ ] I do not authorized the release of information. [ ] I have my own donors.			
11. Have you or do you plan to submit a claim for benefits under the Worker's Compensation Program?      [ ] Yes      [ ] No			
12. Have you, or do you plan to apply to the Office of Personnel Management for disability retirement?      [ ] Yes      [ ] No			
13. Read the following carefully before signing:  Any person who knowingly makes any false statement for misrepresentation of fact or commits fraud to obtain emergency leave from the Leave Bank is subject to civil or administrative remedies as well as felony criminal prosecution, and may, under appropriate criminal provisions, be punished by fine or imprisonment or both.  I understand that my signature on this application constitutes a relinquishment of any right to request a waiver of erroneous payment of wages and serves as due process in this regard under the Federal Dept Collection Act of 1982. This applied only in the event I am erroneously overpaid as a result of my status as an approved leave recipient under the Voluntary Leave Transfer and Leave Ban Programs.			
14. Signature of Applicant (or person acting on employee's behalf)			Date
Privacy Act Statement: The information requested on this form is for the use of determining the employee's eligibility to participate in the voluntary Leave Transfer Ban as authorized by Public Law 103-103. Provision of this information is voluntary, but failure to provide all of the requested information will result in your request not being processed. The information provided could be disseminated to the Office of Personnel management, the Office of Management and Budget, the General Accounting Office, or other government agencies to satisfy reporting requirements under this program, or to publicize, if authorized, your need to leave donors.			

**Medical Documentation (to be completed by Physician)**

16. Provide the beginning date of the medical emergency.

17. Total number of hours or days requested.

18. Briefly describe the nature, severity, and anticipated duration of the medical emergency, and if it is a recurring one, the appropriate duration of the medical emergency of the applicant or the medial emergency of the applicant's immediate family member who requires care and attendance. A "medical emergency" is medical condition of an employee or family member that would most likely require a prolonged absence from work and would result in a substantial loss of income because of the unavailability of paid leave.

19. Physician's Signature and Telephone Number

20. Date

Any person who knowingly makes any false or misrepresentation of act or commits fraud to obtain leave from the Leave Bank is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by fine or imprisonment or both.