

MSFC REQUEST FOR ADVANCED SICK LEAVE, VOLUNTARY LEAVE TRANSFER PROGRAM, LEAVE DONOR PROGRAM, OR LEAVE WITHOUT PAY

PART I - EMPLOYEE INFORMATION (All requesters must complete this section)

EMPLOYEE'S NAME:	ORG. SYMBOL:	WORK PHONE:
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SOCIAL SECURITY NUMBER:	POSITION TITLE/GRADE:
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Check, if applicable

PART II - REQUEST FOR ADVANCED SICK LEAVE (Complete this section ONLY if you wish to request administrative approval of advanced sick leave)

NUMBER OF HOURS BEING REQUESTED:	BEGINNING DATE (Month/Day/Year):	ENDING DATE (Month/Day/Year):
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REQUESTED LEAVE WILL BE USED: <input type="checkbox"/> Continuously <input type="checkbox"/> Intermittently	PERSON UNDER DOCTOR'S CARE: <input type="checkbox"/> Myself <input type="checkbox"/> Family Member	FAMILY DOCTOR OR CONSULTING DOCTOR:
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I have attached a signed, original, doctor's statement (on doctor's letterhead) with a diagnosis and an approximate ending date of the medical emergency.

EMPLOYEE'S SIGNATURE:	DATE:
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SUPERVISOR'S CERTIFICATION: I have reviewed the employee's request and determined that it is a deserving case for the advancement of sick leave. The employee's performance and conduct are satisfactory, and the amount of advanced sick leave requested will not exceed the amount the employee is reasonably expected to accrue.

CONCURRENCE		APPROVAL/DISAPPROVAL	
FIRST LEVEL SUPERVISOR'S SIGNATURE:	DATE:	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	
SECOND LEVEL SUPERVISOR'S SIGNATURE:	DATE:	MANAGER, HUMAN RESOURCES DEPARTMENT SIGNATURE:	DATE:
		_____	_____

Check, if applicable

PART III - REQUEST TO PARTICIPATE IN VOLUNTARY LEAVE TRANSFER PROGRAM (Complete this section ONLY if you wish to request approval for participation in the Voluntary Leave Transfer Program)

REASON FOR REQUEST:	PERSON UNDER DOCTOR'S CARE:	FAMILY DOCTOR OR CONSULTING DOCTOR:
<input type="checkbox"/> Personal Medical Emergency <input type="checkbox"/> Family Member Medical Emergency	<input type="checkbox"/> Myself <input type="checkbox"/> Family Member BEGINNING DATE: ENDING DATE:	

I certify that this request is to avoid the loss of income due to inadequate annual and sick leave. I further certify that I will have at least 24 hours of Leave Without Pay (LWOP); thereby creating a personal hardship. I have attached a signed, original doctor's statement (on doctor's letterhead), with a diagnosis and an approximate ending date of the medical emergency.

I DO I DO NOT authorize the release of the following information to potential donors:
(Please check all applicable items)

My name as a leave recipient
 My medical emergency
 My family member's medical emergency

EMPLOYEE'S SIGNATURE: _____	DATE: _____
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CONCURRENCE		APPROVAL/DISAPPROVAL	
FIRST LEVEL SUPERVISOR'S SIGNATURE:	DATE:	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	
SECOND LEVEL SUPERVISOR'S SIGNATURE:	DATE:	MANAGER, HUMAN RESOURCES DEPARTMENT SIGNATURE:	DATE:
		_____	_____

EMPLOYEE'S NAME:	ORG. SYMBOL:
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<input type="checkbox"/> Check, if applicable	PART IV - REQUEST TO DONATE ANNUAL LEAVE (Complete this section ONLY if you wish to donate annual leave)
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I understand the maximum amount of annual leave that may be donated during the leave year shall be the lesser of -- (1) one-half of the amount of annual leave I would be entitled to accrue during the leave year in which the donation is made (unless leave recipient is a family member); or (2) the number of hours remaining in the leave year (as of the date of the donation) for which the leave donor is scheduled to work and receive pay. I also understand that I MAY NOT donate leave to my supervisor. Therefore, I request the donation of annual leave hours (indicated below) to the employee indicated.

TRANSFER TO

EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL):	NUMBER OF HOURS TO BE DONATED:
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ORGANIZATION CODE:	AGENCY/DEPARTMENT:
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<div style="border: 1px solid black; padding: 2px;">20 _____</div>	YEAR RETURN OPTION - Enter the year in which the leave will be returned to Leave Donor if the Leave Recipient does not use it and the emergency ends. The Leave Donor has the option of having the leave returned in the current Leave Year or the next Leave Year to prevent a use-or-lose situation.
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Check the appropriate box below for release of information: <input type="checkbox"/> My name MAY be released to the person to whom I am donating this leave. <input type="checkbox"/> My name MAY NOT be released to the person to whom I am donating this leave.	SIGNATURE/DATE:
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<input type="checkbox"/> Check, if applicable	PART V - REQUEST FOR LEAVE WITHOUT PAY (LWOP) (Complete this section ONLY if you wish to request administrative approval of Leave Without Pay for more than 30 consecutive days.) (THIS REQUEST MUST BE ROUTED THROUGH YOUR ADMINISTRATIVE OFFICER.) If this request for LWOP is for medical reasons, attach to this form a signed, original, doctor's statement (on doctor's letterhead) with a diagnosis and an approximate ending date of the medical emergency.
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NUMBER OF HOURS BEING REQUESTED:	BEGINNING DATE (Month/Day/Year):	ENDING DATE (Month/Day/Year):
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JUSTIFICATION:

I certify that I will return to my position at MSFC at the end of the approved period.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

In accordance with MM 3000.1B, Section 6.212, and after consultation with the employee, it has been determined that there is a reasonable expectation that the employee will return at the end of the approved LWOP period. Approval of this request will benefit NASA/MSFC by (check all items that apply):

<input type="checkbox"/> Increasing the job ability of the employee	<input type="checkbox"/> Ensuring retention of a very desirable employee
<input type="checkbox"/> Protecting or improving employee's health	<input type="checkbox"/> Furthering of a program of interest to the Government

CONCURRENCE		APPROVAL/DISAPPROVAL	
FIRST LEVEL SUPERVISOR'S SIGNATURE:	DATE:	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	
SECOND LEVEL SUPERVISOR'S SIGNATURE:	DATE:	MANAGER, HUMAN RESOURCES DEPARTMENT SIGNATURE:	DATE:
		_____	_____

NOTICE: TO ARRANGE FOR PAYMENT OF HEALTH INSURANCE PREMIUMS DURING THIS PERIOD OF LEAVE WITHOUT PAY, CONTACT THE MSFC PAYROLL OFFICE, MAIL CODE: RS10, PHONE: 544-7345.