

DoDDS (TP-1701)

REQUEST FOR LEAVE OR APPROVED ABSENCE

1. NAME <i>(Last, First, Middle Initial)</i> Mouse, Mickey M	SOCIAL SECURITY NUMBER 000-00-1234
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2. **ORGANIZATION/SCHOOL**

KAISERSLAUTERN DISTRICT

3. TYPE OF LEAVE/ABSENCE <small>(Check appropriate box below)</small>	DATE/S <small>(Fill out date/s below)</small>		TIME <small>(Fill out time/s below)</small>		TOTAL AMOUNT OF DAYS REQUESTED ↗
	From ↗	To ↗	Half Day .5 From ↗	Full Day 1.0 To ↗	
<input checked="" type="checkbox"/> Accrued Sick Leave ↗ <small>"Educator Leave"</small>	17 Jul 13	17 Jul 13	0700	1600	1
<input type="checkbox"/> Advance Sick Leave ↗ <small>"Educator Leave"</small>					

Purpose Medical/dental/optical examination of requesting employee Other
 Care of family member/bereavement, including medical/dental/optical examination of family member.

If sick leave or leave without pay will be used under the Family and Medical Leave Act of 1993, please provide the following information. I hereby invoke my Family and Medical Leave for ↗:

Birth/Adoption/Foster Care Serious Health Condition of Spouse, /Son, Daughter or Parent Serious Health Condition of Self

Contact your supervisor and/or your personnel office to obtain additional information about entitlements and responsibilities under the Family and Medical Leave Act of 1993.

<input type="checkbox"/> Any Purpose Leave/APL ↗					
<input type="checkbox"/> Admin Leave for TDY/Training/Workshops ↗					
<input type="checkbox"/> Admin Leave for HHGS/PCS/Moving ↗					
<input checked="" type="checkbox"/> AUL	3 Jul 13	31 Jul 13	0700	1600	16
<input type="checkbox"/> Leave Without Pay ↗ <small>(If Sick Leave Balance "0")</small>					

4. **REMARKS**
Furlough days 8 Jul, 15 Jul, 22 Jul

5. **CERTIFICATION:** I hereby request leave/approved absence from duty as indicated above and certify that such leave/absence is requested for the purpose 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 of information on this form may be grounds for disciplinary action, including removal.

EMPLOYEE'S SIGNATURE **DATE:**

6. **OFFICIAL ACTION ON REQUEST:** **APPROVED** **DISAPPROVED** (If disapproved, give reason)

SUPERVISOR'S SIGNATURE **DATE:**

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 Federal information is required for evaluation of leave administration; or 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 9397. 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 those indicated above, it may provide you with an additional statement reflecting those purposes.