EMAIL FORM

Competency/Serial Number:

Date:

APPLICATION FOR ADVANCE OF SICK LEAVE

This form is to be used to request an advance of sick leave.

1. Under REQUEST/REMARKS the employee will fill in the number of hours requested for advance sick leave. The expected beginning and ending date for this request must be filled in by the employee.
2. Signed and dated medical substantiation of a medical illness or disability must accompany this request.
3. The Supervisor should only approve advance sick leave if it appears likely that the employee will return to duty long enough to ear the advance leave.
4. If approved, forward the form to :
   SSC Atlantic Command Payroll Office
   Charleston, South Carolina

The immediate supervisor retains one copy. One copy is forwarded to the petitioning employee's home address by the immediate supervisor.

EMPLOYEE NAME (Last, First, MI)	PERSONNEL NUMBER

MAILING ADDRESS

REQUEST/REMARKS

This request is for ______ hours of advanced sick leave as supported by the attached medical documentation.

This request for advanced sick leave covers the following period from ______ to ______

In my request for advance sick leave, I have taken into consideration the fact that my cumulative total of advance sick leave owed, through this request or a combination of this and others, may not amount to more than 240 hours. (Full time employees only)

PETITIONING EMPLOYEE (Printed Name)	DATE	SIGNATURE
IMMEDIATE SUPERVISOR (Printed Name)	DATE	SIGNATURE
SECOND LEVEL - If applicable (Printed Name)	DATE	SIGNATURE

DETERMINATION/AUTHORIZATION OF ADVANCE SICK LEAVE

______ hours of advanced sick leave are approved IAW the provisions of DoD Financial Management Regulations, Vol 8, Civilian Pay and procedures. You are hereby advised that in the event you leave government service you must repay any advanced sick leave unless the separation is caused by death, disability, retirement, or a disability which prevents you from returning to duty or continuing in the service, and which is the basis of the separation as determined by the employing office on medical evidence acceptable to it.

HIGHEST LEVEL COMPETENCY LEAD (Printed Name)	DATE	SIGNATURE