Request for Leave or Approved Absence

1. Name (Last, first, middle)				2. Employee or Social Security Number (Enter only the last 4 digits of the Social Security Number (SSN))				
3. Organization								
4. Type of Leave/Absence (Check appropriate box(es) below)		Date		Time From To		5. Family and Medical Leave		
Accrued Annual Leave	From	To	FIOIII	10	Hours	If annual leave, sick leave, or		
						leave without pay will be used under the Family and Medical		
Restored Annual Leave						Leave Act of 1993, please provide		
Advanced Annual Leave						the following information:		
Accrued Sick Leave						I hereby invoke my entitlement to Family and Medical Leave for:		
Advanced Sick Leave						Birth/Adoption/Foster Care		
Purpose: Illness/injury/incapacitation of requesting employee Medical/dental/optical examination of requesting employee						Serious health condition of spouse, son, daughter, or		
Care of family member, including medical/dental/optical examination of family						parent Serious health condition of		
☐ member, or bereavement						└─ self		
Care of family member with a serious health condition Contact your supervisor a								
Other						your personnel office to obtain additional information about your		
Compensatory Time Off						entitlements and responsibilities		
Other Paid Absence (Specify in Remarks)						under the Family and Medical Leave Act. Medical certification of a serious health condition may be required by your agency.		
Leave Without Pay								
7. Certification: I hereby requerequested for the purpose(s) indicat approved absence (and provide add be grounds for disciplinary action, in	ed. I understa itional docume	nd that I mus ntation, inclu	st comply with m	y employing	agency's pro	cedures for requesting leave/		
7a. Employee Signature					7b. Date	3		
8a. Official Action on Request: Approved			Disap			oved, give reason. If annual leave, ion to reschedule.)		
8b. Reason for Disapproval:								
8c. Supervisor Signature					8d. Date			
			ACY ACT STATEM					
Section 6311 of Title 5, United States Coroffice to approve and record your use of I compensation regarding a job connected Benefits carriers regarding a claim; to a F civil or criminal law; to a Federal agency General Accounting Office when the information responsibilities for records management.	leave. Additional injury or illness; Federal, State, or when conducting mation is require	disclosures of to a State une r local law enfo g an investigation	the information ma employment compe rcement agency wl on for employment	ny be: to the Dennisation office rennisen your agences or security rea	epartment of L egarding a clai y becomes aw asons; to the C	abor when processing a claim for m; to Federal Life Insurance or Health are of a violation or possible violation of ffice of Personnel Management or the		
Public Law 104-134 (April 26, 1996) requ number. This is an amendment to Title 3 delay or prevent action on the application provide you with an additional statement	1, Section 7701. n. If your agency	Furnishing the uses the inform	social security nur	nber, as well as	s other data, is	voluntary, but failure to do so may		

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