APPLICATION FOR THE NIDCR VOLUNTARY LEAVE TRANSFER PROGRAM

Part I - INFORMATION ON THE APPLICANT FOR THE VLTP

Name of Applicant	Position Title	Pay Plan, Series & Grade

Division/Lab/Branch or Office

Timekeeper's Name and Phone	Timekeeper No.	Person Affected by the Medical Emergency
		☐ Applicant ☐ Family Member

Description of Medical Emergency: A brief description of the nature, severity, and anticipated duration of the personal or family medical emergency affecting the applicant. Attach the Physician's Form affirming the diagnosis, prognosis and date when you can be expected to return to work. If a family medical emergency, address the issue of why you must be absent to care for the family member.

Estimated date of return from medical emergency:

I do ☐ do not ☐ authorize information on this form and my written description of the medical emergency be placed on VLTP Web Sites in the area of distribution

I do ☐ do not ☐ wish to approve the contents of the memo to staff soliciting the donation of leave before it is distributed.

I do ☐ do not ☐ wish to give the timekeeper read access only rights for DFAS.

Check the following to indicate the level of distribution desired:

☐ NIDCR Wide

☐ NIH Wide

☐ DHHS Website

☐ I understand that I must notify my leave approving official/supervisor and the NIDCR VLTP & ITAS Coordinators in writing when the medical emergency is over.

☐ During the course of the medical emergency, I expect to incur Leave Without Pay (LWOP) of 24 hours or more.

During the course of my medical emergency I am estimating that I will need to have # ________ additional hours of leave.

Applicant's, Family Member's or Personal Representative's Signature

______________________ ____________ **Date**

☐ I hereby certify that if the applicant does not receive leave donations, he/she will incur at least 24 hours LWOP.

Signature of Applicant's Timekeeper

______________________ ____________ **Date**

Part II - RECOMMENDATION FOR APPROVAL OF APPLICATION FOR THE VLTP

☐ I hereby certify that if the applicant does not receive leave donations, he/she will incur at least 24 hours LWOP.

Signature of Applicant's Leave Approving Official/Supervisor

______________________ ____________ **Date**

Part III - APPROVAL OF PARTICIPATION IN THE VLTP

Signature of the NIDCR VLTP Coordinator:	**Date:**

PRIVACY ACT STATEMENT

Section 6332 of Title 5 of the U.S. Code authorizes collection of this information. The primary use of this information is by management and your payroll office to approve participation in the Leave Transfer Program and transfers of accrued leave. Additional disclosures of the information may be to: operating officials in carrying out their personnel management responsibilities; for staffing and budgetary planning and control; 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; and to a Federal agency when conducting an investigation on you for employment or security reasons. Furnishing the information on this form is voluntary, but failure to do so may result in disapproval of this request.