

| <b>1. NAME</b> (Last, First, Middle Initial)    |            | <b>2. ORGANIZATION:</b><br>FHWA, WFLHD |         |       |         |             |
|---|------------|--|---------|-------|---------|-------------|
| 3. TYPE OF LEAVE  | T&A Code   | DATE                                   |         | TIME  |         | TOTAL HOURS |
|   |            | From                                   | Through | From  | Through |             |
| Annual Leave  | 01         |  |         |       |         |             |
|   | 01         |  |         |       |         |             |
|   | 01         |  |         |       |         |             |
| Sick Leave  | 02         |  |         |       |         |             |
|   | 02         |  |         |       |         |             |
|   | 02         |  |         |       |         |             |
| Advanced Sick Leave   | 02         |  |         |       |         |             |
| Family and Medical Leave<br>(Please complete Block 4. below.)   | FFI<br>FFF |  |         |       |         |             |
| TRAVEL Compensatory Time Leave  | 047        |  |         |       |         |             |
| Compensatory Time Leave   | 04         |  |         |       |         |             |
| Excused Leave Blood Donation  | 08         |  |         |       |         |             |
| Leave Without Pay   | 12         |  |         |       |         |             |
| Restored Annual Leave   | 16         |  |         |       |         |             |
| Time-Off Award Leave  | 22         |  |         |       |         |             |
| OTHER   |            |  |         |       |         |             |
| <b>4. FAMILY AND MEDICAL LEAVE:</b><br><input type="checkbox"/> Care of family member/bereavement, including Medical/Dental/Optical examination of family member.<br><br>If annual leave, sick leave, or leave without pay will be used under the Family and Medical Leave Act of 1993, please provide the following information:<br><input type="checkbox"/> I hereby invoke my entitlement of Family and Medical Leave for:<br><input type="checkbox"/> Birth/Adoption/Foster Care<br><input type="checkbox"/> Serious Health Condition of Spouse, Son, Daughter, or Parent<br><input type="checkbox"/> Serious Health Condition of Self<br><br>Contact your supervisor and/or your personnel office to obtain additional information about your entitlements and responsibilities under the Family and Medical Leave Act of 1993.  |            |  |         |       |         |             |
| <b>5. REMARKS:</b>  |            |  |         |       |         |             |
| <b>6. CERTIFICATION:</b> I hereby request leave/approved absence from duty as indicated above and certify that such leave/absence is requested for the purpose(s) 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 SIGNATURE:   |            |  |         | DATE: |         |             |
| <b>7. OFFICIAL ACTION ON REQUEST:</b> <input type="checkbox"/> Approved <input type="checkbox"/> Disapproved<br>(If disapproved, give reason. If annual leave, initiate action to reschedule.)  |            |  |         |       |         |             |
| SIGNATURE:  |            |  |         | DATE: |         |             |
| <b>PRIVACY ACT STATEMENT</b>  |            |  |         |       |         |             |
| 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 any record you 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 information is required for evaluation of leave administration; or to the General Services Administration in connection with its responsibilities for records management. |            |  |         |       |         |             |