BP-A0832 **VOLUNTARY LEAVE TRANSFER (VLTP) and VOLUNTARY LEAVE**
JUNE 10 **BANK (VLBP) RECIPIENT APPLICATION** CDFRM
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

Please print or type all information

1. Applicant's Name:	2. Social Security Number:
3. Position Title:	4. Position Series/Grade:
5. Home Address and Telephone #:	6. Agency/Component/Location (District)/ Telephone #:
7. Timekeeper's Name/Location (District):	8. Timekeeper's Telephone/Fax #'s:

9. ***Membership in the VLBP does not automatically entitle an employee to leave from the Leave Bank.*** However, employees may apply to **BOTH** the Voluntary Leave Transfer and the Voluntary Leave Bank (***membership required***) Programs at the same time for the same medical emergency. Please indicate which Program(s) you are applying for. **[ ] VLTP [ ] VLBP [ ] BOTH**

10. Leave balances as of the end of the last pay period:
_____ Annual _____ Sick _____ LWOP _____ AWOL _____ COMP
How many hours of LWOP have been used for this medical emergency: _____

11. Approximate date/pay period when all available leave is exhausted:

12. Number of hours requested after all available leave has been exhausted:
(Note: If applicable, this total should include all advanced leave and LWOP hours that occurred due to this medical emergency.)

13. Number of hours of advanced leave have been approved for this medical emergency:
_____ Annual _____ Sick

14. Applicants under the VLTP may authorize the release of information about their medical emergency to publicize their need for leave donations.
[ ] I **DO** authorize the release of information to publicize my need for leave.
[ ] I **DO NOT** authorize the release of information.
[ ] I have my own donors.

If you **DO** AUTHORIZE the release of medical information to publicize your need for leave, please provide a narrative description of no more than twenty(20) words, below:

15. Have you or do you plan to submit a claim for benefits under the ***Workers' Compensation Program***?
[ ] Yes [ ] No
If yes, what is the date of your claim?

16. Have you, or do you plan to apply to the Office of Personnel Management for ***disability retirement***?
[ ] Yes [ ] No
If yes, (a) what is the date of your application _____ and
(b) is your application based on the same medical condition for which you are requesting leave from the leave sharing program(s)?
[ ] Yes [ ] No

17. Immediate Supervisor's Name/Title/Address/Telephone #:

18. Supervisor's Comments:

19. Supervisor's Signature*	20. Date

This signature is used only for the purpose of making the signer aware of the applicant's intent to participate in the leave sharing program. The supervisor retains the authority to deny a request to use emergency leave just as he/she may deny a request to use annual leave.

TO BE COMPLETED BY APPLICANT'S PHYSICIAN

21. Provide the beginning date of the personal (or family) medical emergency:

22. Provide the anticipated ending date (return to work):

23. Provide the medical re-evaluation date:

24. Briefly describe the **nature, severity and anticipated duration of the medical emergency.** If the emergency is a recurring one, provide the approximate duration of the medical emergency of the applicant (or immediate family member who requires care). A "medical emergency" is a medical condition that would most likely require prolonged absence from work and would result in a substantial loss of income (24 hours or more) because of the unavailability of paid leave. ***(If you prefer, the physician's statement may be submitted on the physician's letterhead.)*** ***IF WE DO NOT RECEIVE THE REQUESTED INFORMATION, THIS WILL DELAY THE APPLICATION.***

25. Physician's Name and Telephone #:	26. Date:

27. Physician's Signature:

Read the following carefully before signing:

Any person who knowingly makes any false statement, misrepresentation, containment of fact or fraud to obtain emergency leave from the Leave Transfer and/or Leave Bank Program(s) is subject to civil or administrative remedies as well as felony criminal prosecution, and may, under appropriate criminal provisions, be punished by fine or imprisonment or both.

I understand that my signature on this application constitutes a relinquishment of any right to request a waiver of erroneous payment of wages and serves as due process in this regard under the Federal Debt Collection Act of 1982. This applies only in the event I am erroneously overpaid as a result of my status as an approved leave recipient under the Voluntary Leave Transfer and/or Leave Bank Program(s).

28. Applicant's Signature:	29. Date:
30. Name of person acting on behalf of Applicant and Telephone #:	31. Relationship to Applicant:
32. Signature of person acting on behalf of Applicant:	33. Date:

Privacy Act Statement: The information requested on this form is for the use of determining the employee's eligibility to participate in the Voluntary Leave Transfer and Leave Bank as authorized by Public Law 103.103. Provisions of this information is voluntary, but failure to provide all of the requested information will result in your request not being processed. The information provided could be disseminated to the Office of Personnel Management, the Office of Management and Budget, the General Accounting Office or other government agencies to satisfy reporting requirements under this Program, or to publicize if authorized, your need to leave donors.