U.S. DEPARTMENT OF AGRICULTURE
FOOD SAFETY AND INSPECTION SERVICE

For Personnel Use Only:

LEAVE BANK PROGRAM RECIPIENT APPLICATION

INSTRUCTIONS: Use this form to apply as a recipient in the leave bank program under 5 CFR Part 630, Section 630.1001. Attach to this form, the appropriate medical documentation describing your medical emergency. The medical documentation shall include diagnosis or prognosis and anticipated duration of the condition. After completing this form, have your supervisor sign concurrence and forward your application to the Leave Bank Coordinator (LBC). Please see FSIS Directive 4630.2, for additional information. You will be notified of approval or disapproval within 10 business days of receipt of the completed application.

PART A. COMPLETED BY RECIPIENT (This form may be completed by someone acting on behalf of the recipient)

1. Name of Applicant: (Last, First, MI)

2. Position Title:	3. Series and Grade:	4. Organization: (Program, Division/District, Branch/Circuit)
5. Office Location/Establishment: (City, State)	6. Work Phone: (1234567890)	7. Applicant's Personal Phone: (1234567890)
8. Anticipated or Actual Duration of Medical Emergency: (As described in the medical documentation included with this application) Beginning Date: (mm/dd/yyyy)	Ending Date: (mm/dd/yyyy)	9. Approximate Number of Leave Hours Needed for this Emergency:

10. Type of Medical Emergency: ☐ Personal ☐ Family - Related: (See **Note** below)

11. Leave Category to Apply Donated Leave: (Indicate the Order in which the Donated Leave should be Applied (Assign 1st, 2nd, 3rd, 4th))

____ Current Use ____ Advanced Sick Leave ____ Advanced Annual Leave ____ Leave Without Pay (LWOP)

Note: When applying to be a recipient due to the medical emergency of a family member, all entitlements to Sick Leave for Family Care (SLFC) must be exhausted. Additional information on SLFC can be found in FSIS Directive 4630.2, Revision 2, Part III, Section Three.

PART B. RECIPIENT OR DESIGNEE AND SUPERVISOR CERTIFICATION

I certify that (1) I have been affected by the medical emergency described in the attachment since the date indicated above, (2) expect to be absent from duty without paid leave for at least 24 hours due to a qualifying medical emergency. I further certify that I am not receiving unemployment benefits or workers' compensation benefits in connection with this medical emergency for which I am requesting leave donations.

12. Signature of Applicant or Designee:	13. Date: (mm/dd/yyyy)

Blocks 14. through 17. To Be Completed by Recipient's Supervisor

14. Signature of Supervisor:	15. Date: (mm/dd/yyyy)	16. Concurrence: ☐ Yes ☐ No	17. Supervisor's Work Phone: (1234567890)

PART C. AGENCY REVIEW AND DECISION (To be completed by the Office of Human Resources)

18. Applicant's Current Annual Leave Balance:	19. Applicant's Current Sick Leave Balance:	20. Applicant's Adjudication: ☐ Approved ☐ Disapproved (Explain below)
21. Reason for Disapproval:		24. Number of Leave Bank Hours Provided to Recipient:
22. Signature of Approving Official:	23. Date: (mm/dd/yyyy)	

PART D. APPLICATION SUBMISSION

25. Submit the complete application package and attachments to the LBP at: LeaveBankProgram@usda.gov with the subject 'LBP Recipient Application'.

PRIVACY ACT STATEMENT

U.S.C 6311 authorizes collection of this information. Your personal identifiable information is requested solely for the purposes of positively identifying leave donors so that donated leave can be deducted from the proper account. Although the disclosure of this information is voluntary, failure to furnish this information may result in disapproval of this application.

Instructions for Applying to Become an Approved Leave Recipient

To Qualify to Become a Recipient Under the Leave Bank Program (LBP):

1. You must be a current member of the LBP;
2. You must be, or expect to be absent from duty for a prolonged period due to a personal or family-related medical emergency;
3. You must have already been, or expected to be, absent from duty without pay, or be on advanced leave for at least 24 hours (or a prorated amount for part-time employees) during the medical emergency. If you have, or are expected to have a personal or family-related medical emergency, you must have already, or projected to exhaust your accrued annual and sick leave prior to receiving donated leave from the program or from colleagues; and
4. Your absence from work must have been approved by your supervisor (i.e., you must have applied and been approved for an approved leave status such as, paid leave, advanced leave or leave without pay).

Applying to Become an Approved Recipient Under LBP:

Part A. - To be Completed by Recipient or someone acting on behalf of the recipient:

1. **Name of Applicant:** (Last, First, MI) **-** Enter your full name. Do not use nicknames.
2. **Position Title:** Enter your Position Title (E.g., Food Inspector, Consumer Safety Inspector, Human Resources Specialist, etc.).
3. **Series and Grade:** Enter your Series and Grade (E.g., GS-201-12, GS-701-11, etc.).
4. **Organization:** (Program, Division/District, Branch/Circuit) **-** Enter your Organization (E.g., Office of Field Operations/Alameda District/Oakland Circuit, Office of Employee Experience and Development/OEDB, etc.).
5. **Office Location/Establishment:** Enter your office location or establishment (City and State).
6. **Work Phone:** Enter your work phone. Leave blank if you do not have a work phone number.
7. **Applicant's Personal Phone:** Enter applicant's personal phone number.
8. **Anticipated or Actual Duration of Medical Emergency:** (As described in the medical documentation included with this application) **-** Enter the beginning and ending dates of the medical emergency. If the actual ending date is unknown, provide an estimate of the ending date based on the recommended recovery in the supporting medical documentation provided by the physician. If the leave needed is intermittent, the ending date cannot exceed 6 months from the beginning date. **Example of intermittent use:** Employee is in kidney failure and will require 4-hour dialysis treatments twice weekly.
9. **Approximate Number of Leave Hours Needed for this Emergency:** Enter the approximate number of leave hours needed for this emergency.
10. **Type of Medical Emergency:** Select the type of Medical Emergency; 'Personal' or 'Family - Related'.
11. **Leave Category to Apply Donated Leave:** (Indicate the Order in which the Donated Leave should be Applied (Assign 1, 2, 3, 4)) **-** Use the drop down to select the order in which the donated leave should be applied. (E.g., 1 - Current Use, 4 - Advanced Sick Leave, 2 - Advanced Annual Leave, 3 - LWOP)

    Note: Donated leave can be used retroactively to cover paid leave, LWOP, or advanced leave used during the period of the medical emergency. However, donated leave cannot be used to replace Absent Without Leave (AWOL).

Part B. - Recipient or Designee and Supervisor Certification:

12. **Signature of Applicant or Designee:** Sign electronically using your LincPass or print and sign.
13. **Date: (mm/dd/yyyy) -** Enter date the form was signed. Submit completed form to your supervisor for their signature.

Blocks 14. through 17. to be completed by Recipient's Supervisor

14. **Signature of Supervisor:** Sign electronically using your LincPass or print and sign indicating concurrence that the employee:
    a. Requested leave for the time period indicated in block 8,
    b. Has or expects to exhaust all available annual and sick leave, and,
    c. Is or expects to be in a non-paid status or using advanced leave for at least 24 hours.
15. **Date: (mm/dd/yyyy) -** Enter date the form was signed.
16. **Concurrence:** Select 'Yes' or 'No' to indicate your concurrence.
17. **Supervisor's Work Phone:** Enter your work phone. Leave blank if you do not have a work phone number.

Part C. - Agency Review and Decision: Leave blank. To be completed by the Office of Human Resources.

18. **Applicant's Current Annual Leave Balance:** Leave blank.
19. **Applicant's Current Sick Leave Balance:** Leave blank.
20. **Applicant's Adjudication:** Leave blank.
21. **Reason for Disapproval:** Leave blank.
22. **Signature of Approving Official:** Leave blank.
23. **Date: (mm/dd/yyyy) -** Leave blank.
24. **Number of Leave Bank Hours Provided to Recipient:** Leave blank.

Part D. - Application Submission:

25. Submit the complete application package and attachments to the LBP at: **LeaveBankProgram@usda.gov** with the Subject 'LBP Recipient Application'.

    Note: In order for your recipient request to be processed, your application must be complete, and all necessary forms included.