admin
vacation

THE WHITE HOUSE

WASHINGTON

March 30, 1993

MEMORANDUM FOR ALL WHITE HOUSE OFFICE,
OFFICE OF THE VICE PRESIDENT AND
OFFICE OF POLICY DEVELOPMENT EMPLOYEES

FROM: DAVID WATKINS D. Watk
ASSISTANT TO THE PRESIDENT FOR
MANAGEMENT AND ADMINISTRATION

SUBJECT: Vacation and Sick Leave Policy

Outlined below is a summary of the vacation and sick leave policy for all White House Office (WHO), Office of the Vice President (OVP), and Office of Policy Development (OPD) employees. For more details on any of the policies call Vicki Reider of the Office of Administration (OA) at extension 2260.

ANNUAL LEAVE (VACATION)

1. Full-time federal employees (other than Commissioned Officers) accrue leave each pay period. The amount of leave you accrue depends on how long you have worked for the federal government. If you have worked for the government:

   a. Less than 3 years, you accrue 4 hours of leave per pay period, for an annual total of 2.5 weeks (13 working days).

   b. Between 3 years and 14 years, you accrue 6 hours of leave per pay period for an annual total of 4 weeks (20 working days).

   c. 15 or more years, you accrue 8 hours of leave per pay period for an annual total of over 5 weeks (26 working days).

   NOTE: Part-time employees accrue leave at a different rate than full-time employees.

2. An employee may accumulate up to 240 hours (30 days) of annual leave and carry that accumulation over from year to year. Annual leave accumulated in excess of 240 hours will be forfeited at the end of the year. Forfeited leave cannot be restored except under exceptional circumstances.

3. Any leave approved in excess of the amount of annual leave remaining to your credit will be considered leave without pay unless your supervisor approves advanced leave (taking leave you have not yet earned but anticipate earning).

4. Commissioned Officers are allowed, with the approval of their department head, up to 3 weeks (15 working days) of compensatory time per year with no accrual by pay period or year to year carryover.

5. Weekends and federal holidays are not part of the normal working schedule and no leave need be taken for these days.

6. Staff must submit a request for leave to their supervisor either by personal memorandum or by completing an Application for Leave (see attached).

7. Upon approval, the staff member must notify the office's designated timekeeper of their impending leave.

8. Staff can take leave at any time during the year. However, you are encouraged to take accrued leave, whenever possible, during the same time period the President and First Family are vacationing so as not to hinder the functioning of the WHO.

SICK LEAVE

1. All full-time employees, regardless of their length of service, will earn sick leave at the rate of 4 hours for each full pay period for an annual total of 2.5 weeks (13 working days).

2. Accumulated sick leave will be recredited to an employee if the employee is reemployed with the government within 3 years after separation.

3. Sick leave taken in excess of the amount remaining in an employee's credit will be automatically charged to annual leave and then to leave without pay when the annual leave balance is exhausted. This is not true if your supervisor approved advanced sick leave.

SF 71
(Revised 3/79)
OFFICE OF PERSONNEL MANAGEMENT
FPM Supple. 990-2, S 2-9

71-112

APPLICATION FOR LEAVE

INSTRUCTIONS: Please complete Items 1-8 after reading the Privacy Act Statement shown below.

1. Name *(Print or type—Last, First, M.I.)*				2. Employee I.D. Number
3. Organizational Unit	4-A Month / Day / Hour / A.M. P.M. — FROM:			4-C Total Number of Hours
5. I hereby request *(If more than one box is checked, explain in Item 6, Remarks):* ☐ Annual Leave. *(Annual leave requested may not exceed the amount available for use during the leave year.)*	4-B Month / Day / Hour / A.M. P.M. — TO:			
☐ Sick Leave. *(Complete reverse side of form.)* ☐ Leave Without Pay. ☐ Compensatory Time. ☐ Other. *(Specify)*	6. Remarks			
	7. Employee's Signature			8. Date *(Month, Day, Year)*

OFFICIAL ACTION ON APPLICATION

☐ Approved ☐ Disapproved *(If disapproved, give reason. If annual leave, initiate action to reschedule.)*	Signature *(Annual leave approved may not exceed the amount available for use during the leave year.)*	Date *(Month, Day, Year)*

NSN 7540-00-753-5067

Please detach this notice before submitting SF 71.

PRIVACY ACT STATEMENT

Section 6311 of Title 5 to the U.S. Code authorizes collection of this information. The primary use of this information is by management and your payroll office to approve and record your 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 on you for employment or security reasons; to the Office of Personnel Management or

(Continued on Reverse)

EMPLOYEE—Check the appropriate box below (Items 1-4) if you are applying for sick leave. If your agency requires such certification, please have your doctor or practitioner complete the Certification section below. Falsification of information in this portion of the form may be grounds for disciplinary action, including dismissal.

1. I was incapacitated for duty by: ☐ Sickness. ☐ Off-The-Job Injury. ☐ On-The-Job Injury. ☐ Pregnancy and Confinement.	2. I was required to care for a member of my family with a contagious disease. *(Give name and relationship of family member, and name of disease.)* ☐
3. I will be undergoing medical, dental, or optical examination or treatment. ☐	4. I was exposed to a contagious disease. *(Give name of disease and circumstances of exposure.)* ☐

CERTIFICATION OF PHYSICIAN OR PRACTITIONER

Employee's Name	Period Under Professional Care *(Indicate Month, Day, Year)* From:	To:

Remarks

I certify that the employee named was under my professional care for the period indicated above, and that the employee's condition during this period made reporting to work inadvisable.

Signature of Physician or Practitioner	Date *(Month, Day, Year)*

General Accounting Office when the information is required for evaluation of leave administration; and to the General Services Administration in connection with its responsibilities for records management.

Where the employee identification number is your Social Security Number, collection of this information is authorized by Executive Order 9397. Furnishing the information on this form, including your Social Security Number, is voluntary, but failure to do so may result in disapproval of this request.

If your agency uses the information furnished on this form for purposes other than these indicated above, it may provide you with an additional statement reflecting those purposes.

*U.S. Government Printing Office: 1991 — 281-782/40128