FOIA Number: 2018-0764-F

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member: Sandra Thurman

Subseries:

OA/ID Number: 40014

FolderID:

Folder Title:
Admin - Forms - Leave Request

Stack:	Row:	Section:	Shelf:	Position:
S	66	5	11	3

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. form	re: Request for leave or approved absence [Personally Identifiable Information] (1 page)	07/28/2000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Sandra Thurman
OA/Box Number: 40014

FOLDER TITLE:
Admin - Forms - Leave Request

2018-0764-F
jm1989

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

REQUEST FOR LEAVE OR APPROVED ABSENCE

1. NAME *(Last, First, Middle Initial)*	2. EMPLOYEE OR SOCIAL SECURITY NUMBER

3. ORGANIZATION

4. TYPE OF LEAVE/ABSENCE *(Check appropriate box(es) below.)*	DATE From:	DATE To:	TIME From:	TIME To:	TOTAL HOURS
☐ Accrued Annual Leave					
☐ Restored Annual Leave					
☐ Advance Annual Leave					
☐ Accrued Sick Leave					
☐ Advance Sick Leave					
Purpose: ☐ Medical/dental/optical examination of requesting employee ☐ Other ☐ Care of family member/bereavement, including medical/dental/optical examination of family member					
☐ Compensatory Time Off					
☐ Other Paid Absence *(Specify in Remarks)*					
☐ Leave Without Pay					

5. FAMILY AND MEDICAL LEAVE

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:

☐ **I hereby invoke my entitlement to Family and Medical Leave for:**

- ☐ Birth/Adoption/Foster Care
- ☐ Serious Health Condition of Spouse, Son, Daughter, or Parent
- ☐ Serious Health Condition of Self

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.

6. REMARKS:

7. CERTIFICATION: 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

8. OFFICIAL ACTION ON REQUEST: ☐ APPROVED ☐ DISAPPROVED

(If disapproved, give reason. If annual leave, initiate action to reschedule.)

SIGNATURE DATE

PRIVACY ACT STATEMENT

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 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 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.

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 those indicated above, it may provide you with an additional statement reflecting those purposes.

REQUEST FOR LEAVE OR APPROVED ABSENCE

1. NAME *(Last, First, Middle Initial)*	2. EMPLOYEE OR SOCIAL SECURITY NUMBER

3. ORGANIZATION

4. TYPE OF LEAVE/ABSENCE *(Check appropriate box(es) below.)*	DATE From:	DATE To:	TIME From:	TIME To:	TOTAL HOURS
☐ Accrued Annual Leave					
☐ Restored Annual Leave					
☐ Advance Annual Leave					
☐ Accrued Sick Leave					
☐ Advance Sick Leave					
Purpose: ☐ Medical/dental/optical examination of requesting employee ☐ Other ☐ Care of family member/bereavement, including medical/dental/optical examination of family member					
☐ Compensatory Time Off					
☐ Other Paid Absence *(Specify in Remarks)*					
☐ Leave Without Pay					

5. FAMILY AND MEDICAL LEAVE

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:

☐ **I hereby invoke my entitlement to Family and Medical Leave for:**

- ☐ Birth/Adoption/Foster Care
- ☐ Serious Health Condition of Spouse, Son, Daughter, or Parent
- ☐ Serious Health Condition of Self

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.

6. REMARKS:

7. CERTIFICATION: 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

8. OFFICIAL ACTION ON REQUEST: ☐ APPROVED ☐ DISAPPROVED

(If disapproved, give reason. If annual leave, initiate action to reschedule.)

SIGNATURE DATE

PRIVACY ACT STATEMENT

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 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 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.

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 those indicated above, it may provide you with an additional statement reflecting those purposes.

REQUEST FOR LEAVE OR APPROVED ABSENCE

1. NAME *(Last, First, Middle Initial)*	2. EMPLOYEE OR SOCIAL SECURITY NUMBER

3. ORGANIZATION

4. TYPE OF LEAVE/ABSENCE *(Check appropriate box(es) below.)*	DATE From:	DATE To:	TIME From:	TIME To:	TOTAL HOURS
☐ Accrued Annual Leave					
☐ Restored Annual Leave					
☐ Advance Annual Leave					
☐ Accrued Sick Leave					
☐ Advance Sick Leave					
Purpose: ☐ Medical/dental/optical examination of requesting employee ☐ Other ☐ Care of family member/bereavement, including medical/dental/optical examination of family member					
☐ Compensatory Time Off					
☐ Other Paid Absence *(Specify in Remarks)*					
☐ Leave Without Pay					

5. FAMILY AND MEDICAL LEAVE

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:

☐ **I hereby invoke my entitlement to Family and Medical Leave for:**

- ☐ Birth/Adoption/Foster Care
- ☐ Serious Health Condition of Spouse, Son, Daughter, or Parent
- ☐ Serious Health Condition of Self

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.

6. REMARKS:

7. CERTIFICATION: 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

8. OFFICIAL ACTION ON REQUEST: ☐ APPROVED ☐ DISAPPROVED

(If disapproved, give reason. If annual leave, initiate action to reschedule.)

SIGNATURE DATE

PRIVACY ACT STATEMENT

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 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 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.

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 those indicated above, it may provide you with an additional statement reflecting those purposes.

REQUEST FOR LEAVE OR APPROVED ABSENCE

1. NAME *(Last, First, Middle Initial)*	2. EMPLOYEE OR SOCIAL SECURITY NUMBER

3. ORGANIZATION

4. TYPE OF LEAVE/ABSENCE *(Check appropriate box(es) below.)*	DATE From:	DATE To:	TIME From:	TIME To:	TOTAL HOURS
☐ Accrued Annual Leave					
☐ Restored Annual Leave					
☐ Advance Annual Leave					
☐ Accrued Sick Leave					
☐ Advance Sick Leave					
Purpose: ☐ Medical/dental/optical examination of requesting employee ☐ Other ☐ Care of family member/bereavement, including medical/dental/optical examination of family member					
☐ Compensatory Time Off					
☐ Other Paid Absence *(Specify in Remarks)*					
☐ Leave Without Pay					

5. FAMILY AND MEDICAL LEAVE

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:

☐ **I hereby invoke my entitlement to Family and Medical Leave for:**

- ☐ Birth/Adoption/Foster Care
- ☐ Serious Health Condition of Spouse, Son, Daughter, or Parent
- ☐ Serious Health Condition of Self

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.

6. REMARKS:

7. CERTIFICATION: 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

8. OFFICIAL ACTION ON REQUEST: ☐ APPROVED ☐ DISAPPROVED

(If disapproved, give reason. If annual leave, initiate action to reschedule.)

SIGNATURE DATE

PRIVACY ACT STATEMENT

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 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 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.

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 those indicated above, it may provide you with an additional statement reflecting those purposes.

REQUEST FOR LEAVE OR APPROVED ABSENCE

1. NAME *(Last, First, Middle Initial)*	2. EMPLOYEE OR SOCIAL SECURITY NUMBER

3. ORGANIZATION

4. TYPE OF LEAVE/ABSENCE *(Check appropriate box(es) below.)*	DATE From:	DATE To:	TIME From:	TIME To:	TOTAL HOURS
☐ Accrued Annual Leave					
☐ Restored Annual Leave					
☐ Advance Annual Leave					
☐ Accrued Sick Leave					
☐ Advance Sick Leave					
Purpose: ☐ Medical/dental/optical examination of requesting employee ☐ Other ☐ Care of family member/bereavement, including medical/dental/optical examination of family member					
☐ Compensatory Time Off					
☐ Other Paid Absence *(Specify in Remarks)*					
☐ Leave Without Pay					

5. FAMILY AND MEDICAL LEAVE

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:

☐ **I hereby invoke my entitlement to Family and Medical Leave for:**

- ☐ Birth/Adoption/Foster Care
- ☐ Serious Health Condition of Spouse, Son, Daughter, or Parent
- ☐ Serious Health Condition of Self

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.

6. REMARKS:

7. CERTIFICATION: 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

8. OFFICIAL ACTION ON REQUEST: ☐ APPROVED ☐ DISAPPROVED

(If disapproved, give reason. If annual leave, initiate action to reschedule.)

SIGNATURE DATE

PRIVACY ACT STATEMENT

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 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 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.

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 those indicated above, it may provide you with an additional statement reflecting those purposes.

REQUEST FOR LEAVE OR APPROVED ABSENCE

1. NAME *(Last, First, Middle Initial)*	2. EMPLOYEE OR SOCIAL SECURITY NUMBER

3. ORGANIZATION

4. TYPE OF LEAVE/ABSENCE *(Check appropriate box(es) below.)*	DATE From:	DATE To:	TIME From:	TIME To:	TOTAL HOURS
☐ Accrued Annual Leave					
☐ Restored Annual Leave					
☐ Advance Annual Leave					
☐ Accrued Sick Leave					
☐ Advance Sick Leave					

Purpose: ☐ Medical/dental/optical examination of requesting employee ☐ Other
☐ Care of family member/bereavement, including medical/dental/optical examination of family member

☐ Compensatory Time Off					
☐ Other Paid Absence *(Specify in Remarks)*					
☐ Leave Without Pay					

5. FAMILY AND MEDICAL LEAVE

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:

☐ **I hereby invoke my entitlement to Family and Medical Leave for:**

☐ Birth/Adoption/Foster Care
☐ Serious Health Condition of Spouse, Son, Daughter, or Parent
☐ Serious Health Condition of Self

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.

6. REMARKS:

7. CERTIFICATION: 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

8. OFFICIAL ACTION ON REQUEST: ☐ APPROVED ☐ DISAPPROVED
(If disapproved, give reason. If annual leave, initiate action to reschedule.)

SIGNATURE DATE

PRIVACY ACT STATEMENT

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 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 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.

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 those indicated above, it may provide you with an additional statement reflecting those purposes.

REQUEST FOR LEAVE OR APPROVED ABSENCE

1. NAME *(Last, First, Middle Initial)*	2. EMPLOYEE OR SOCIAL SECURITY NUMBER

3. ORGANIZATION

4. TYPE OF LEAVE/ABSENCE *(Check appropriate box(es) below.)*	DATE From:	DATE To:	TIME From:	TIME To:	TOTAL HOURS
☐ Accrued Annual Leave					
☐ Restored Annual Leave					
☐ Advance Annual Leave					
☐ Accrued Sick Leave					
☐ Advance Sick Leave					
Purpose: ☐ Medical/dental/optical examination of requesting employee ☐ Other ☐ Care of family member/bereavement, including medical/dental/optical examination of family member					
☐ Compensatory Time Off					
☐ Other Paid Absence *(Specify in Remarks)*					
☐ Leave Without Pay					

5. FAMILY AND MEDICAL LEAVE

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:

☐ **I hereby invoke my entitlement to Family and Medical Leave for:**

- ☐ Birth/Adoption/Foster Care
- ☐ Serious Health Condition of Spouse, Son, Daughter, or Parent
- ☐ Serious Health Condition of Self

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.

6. REMARKS:

7. CERTIFICATION: 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

8. OFFICIAL ACTION ON REQUEST: ☐ APPROVED ☐ DISAPPROVED

(If disapproved, give reason. If annual leave, initiate action to reschedule.)

SIGNATURE DATE

PRIVACY ACT STATEMENT

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 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 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.

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 those indicated above, it may provide you with an additional statement reflecting those purposes.

REQUEST FOR LEAVE OR APPROVED ABSENCE

1. NAME *(Last, First, Middle Initial)*	2. EMPLOYEE OR SOCIAL SECURITY NUMBER

3. ORGANIZATION

4. TYPE OF LEAVE/ABSENCE *(Check appropriate box(es) below.)*	DATE From:	DATE To:	TIME From:	TIME To:	TOTAL HOURS
☐ Accrued Annual Leave					
☐ Restored Annual Leave					
☐ Advance Annual Leave					
☐ Accrued Sick Leave					
☐ Advance Sick Leave					
Purpose: ☐ Medical/dental/optical examination of requesting employee ☐ Other ☐ Care of family member/bereavement, including medical/dental/optical examination of family member					
☐ Compensatory Time Off					
☐ Other Paid Absence *(Specify in Remarks)*					
☐ Leave Without Pay					

5. FAMILY AND MEDICAL LEAVE

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:

☐ **I hereby invoke my entitlement to Family and Medical Leave for:**

- ☐ Birth/Adoption/Foster Care
- ☐ Serious Health Condition of Spouse, Son, Daughter, or Parent
- ☐ Serious Health Condition of Self

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.

6. REMARKS:

7. CERTIFICATION: 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

8. OFFICIAL ACTION ON REQUEST: ☐ APPROVED ☐ DISAPPROVED

(If disapproved, give reason. If annual leave, initiate action to reschedule.)

SIGNATURE DATE

PRIVACY ACT STATEMENT

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 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 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.

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 those indicated above, it may provide you with an additional statement reflecting those purposes.

THE WHITE HOUSE

WASHINGTON

MEMORANDUM FOR MANAGEMENT AND ADMINISTRATION
ATTN: Michelle Salinas

FROM:

SUBJECT: Convention Leave Request

I plan to attend the Convention from Aug. 1, 2000 to Aug. 18, 2000 I have discussed this with my supervisor to make sure that my office will have enough staff coverage during this period.

I plan on taking 112 hours of Annual leave.
(Annual Leave or Leave Without Pay)

Please review the following if you plan to work at the Convention while on leave:

1. **If you make more than $32,380 you cannot accept compensation for Convention work.**

2. **If you make less than $32,380 and expect to be paid while at the Convention, you must contact Dave Apol of White House Counsel's Office at x6-6629 before beginning outside employment.**

If you are taking leave without pay, please contact Management & Administration for information on what happens with your benefits while in a leave without pay status.

Employee Signature: Sandra L Thurman **Date:** 7/28/00

SUPERVISOR AUTHORIZATION

I authorize Sandra Thurman to take leave for the period outlined above.

Supervisor Signature: _____ **Date:** _____

This memorandum serves as the official document for processing your leave. Once this form is completed, send the original copy to Michelle Salinas in Room 145 EEOB, and give your timekeeper a copy. Your timekeeper is responsible for recording the leave in the timekeeping system.

Attachment
cc: Mary Smith, Room 126 ½ EEOB, White House Counsel's Office

THE WHITE HOUSE

WASHINGTON

MEMORANDUM FOR MANAGEMENT AND ADMINISTRATION
ATTN: Michelle Salinas

FROM:

SUBJECT: Convention Leave Request

I plan to attend the Convention from Aug. 11, 2000 to Aug. 18, 2000 I have discussed this with my supervisor to make sure that my office will have enough staff coverage during this period.

I plan on taking 48 hours of Annual leave.
(Annual Leave or Leave Without Pay)

Please review the following if you plan to work at the Convention while on leave:

1. **If you make more than $32,380 you cannot accept compensation for Convention work.**

2. **If you make less than $32,380 and expect to be paid while at the Convention, you must contact Dave Apol of White House Counsel's Office at x6-6629 before beginning outside employment.**

If you are taking leave without pay, please contact Management & Administration for information on what happens with your benefits while in a leave without pay status.

Employee Signature: Cheryl S. Bauerle **Date:** 7/28/00

SUPERVISOR AUTHORIZATION

I authorize Cheryl Bauerle to take leave for the period outlined above.

Supervisor Signature: [signature] **Date:** 7/28/00

This memorandum serves as the official document for processing your leave. Once this form is completed, send the original copy to Michelle Salinas in Room 145 EEOB, and give your timekeeper a copy. Your timekeeper is responsible for recording the leave in the timekeeping system.

Attachment
cc: Mary Smith, Room 126 ½ EEOB, White House Counsel's Office

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. form	re: Request for leave or approved absence [Personally Identifiable Information] (1 page)	07/28/2000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Sandra Thurman
OA/Box Number: 40014

FOLDER TITLE:
Admin - Forms - Leave Request

2018-0764-F
jm1989

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]