LEAVE APPLICATION

1. EMPLOYEE'S NAME (Last)	(First)	(Middle)	2. NAME OF SHIP OR RECEIVING BRANCH AND ACCTG. NO.		3. EMPLOYEE NUMBER
4. SPECIFY TYPE (Annual, LWOP, etc.)			5. SPECIFY TIME (No. of hours)	FROM (hr., day, mo., yr.)	TO (hr., day, mo., yr.)

6. Leave or excused absence as specified above is hereby requested:

(a) [ ] (HOME PORT OR VOYAGE LEAVE). I want leave without pay to cover any period of absence specified above which is not covered by leave with pay or duty status in the Receiving Branch. I understand that leave in the home port separates me from the service of the ship until I return to work aboard ship. I understand that my leave may be cancelled at any time because of operational requirements. *(Employee's initials_____)*

(b) [ ] (VOYAGE SICK LEAVE AND HOME PORT SICK LEAVE EXCEEDING 3 DAYS). A physician's certification of my illness is attached or indicated hereon. (Voyage requests: Department Head certifies when no Medical Officer is aboard.)

(c) [ ] (SICK LEAVE COVERING EXAMINATION OR TREATMENT ONLY). Medical, dental, or optical examination or treatment was performed by--

*(Name of practitioner)*_____.

7. (a) EMPLOYEE'S SIGNATURE	(b) DATE SUBMITTED	8. [ ] APPROVED [ ] DISAPPROVED *(If leave is disapproved, give reason in block 10)*	
(c) FORWARDING ADDRESS AND PHONE NO. *(Notify Ship or Receiving Branch of any change)*		(a) SIGNATURE OF ACTION AUTHORITY	DATE
		(b) TITLE OF ACTION AUTHORITY	

9. REPORTING INSTRUCTIONS
To the employee: You are instructed to return to duty with *(Ship's name or Receiving Branch)*_____

_____ by *(hour, day, month)* _____

10. REMARKS

IMPORTANT: Any false statements in connection with this application may be construed as an attempt to defraud the Government subject to fine or imprisonment, or both.