

DPS Recipient Request Form

Leave Transfer Pool

(PLEASE COMPLETE FORM AND FORWARD TO IMMEDIATE SUPERVISOR; SUPERVISOR WILL RECOMMEND APPROVAL OR DENIAL AND FORWARD TO LEAVE MANAGER)

EMPLOYEE NAME: _____

SCEIS PERSONNEL NUMBER: _____

EMPLOYEE'S DEPARTMENT / DIVISION: _____

PLEASE FURNISH A BRIEF DESCRIPTION OF THE NATURE, SEVERITY, AND ANTICIPATED DURATION OF THE MEDICAL, FAMILY, OR OTHER HARDSHIP SITUATION AFFECTING THE EMPLOYEE: (ATTACH PHYSICIAN CERTIFICATION OR OTHER DOCUMENTATION TO SUPPORT REQUEST)

(EACH SEPARATE REQUEST MUST BE LIMITED TO NO MORE THAN THIRTY (30) WORKING DAYS)
I UNDERSTAND THAT I MUST USE ALL ACCRUED LEAVE BALANCES BEFORE USING TRANSFERRED LEAVE AND WHEN MY PERSONAL EMERGENCY TERMINATES, ANY BALANCE OF TRANSFERRED LEAVE WILL BE RESTORED TO THE APPROPRIATE AGENCY LEAVE TRANSFER POOL ACCOUNT.

EMPLOYEE'S SIGNATURE _____ DATE _____

THIS REQUEST FORM MUST BE APPROVED BY THE EMPLOYING AGENCY. THE SELECTIONS OF THE EMPLOYING AGENCY ARE FINAL, AND THERE IS NO ADMINISTRATIVE OR JUDICIAL APPEAL.

CONCURRENCE	NON-CONCURRENCE	SIGNATURE	DATE
<input type="checkbox"/>	<input type="checkbox"/>	_____ (SUPERVISOR)	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____ (DEPUTY DIRECTOR/DEPT HEAD)	_____

(Additional documentation to support your concurrence or non-concurrence may be attached, if necessary)

ELIGIBLE	INELIGIBLE	DATE
<input type="checkbox"/>	<input type="checkbox"/>	_____ (LEAVE MANAGER)

RECOMMENDED	NOT RECOMMENDED	DATE
<input type="checkbox"/>	<input type="checkbox"/>	_____ (OHR ADMINISTRATOR)