VOLUNTARY LEAVE TRANSFER PROGRAM
NOTICE OF TERMINATION OF MEDICAL EMERGENCY

1. PAYBLOCK NUMBER

2. LEAVE RECIPIENT

a. NAME *(Last, First, Middle Initial)*

b. SOCIAL SECURITY NO.

c. ORGANIZATION

3. LEAVE DATA

a. DATE TRANSFERRED LEAVE BEGAN *(YYMMDD)*	b. NUMBER OF HOURS OF LEAVE TRANSFERRED	c. NUMBER OF HOURS OF TRANSFERRED LEAVE USED

4. DATE OF TERMINATION OF MEDICAL EMERGENCY *(YYMMDD)*

5. REMARKS

6. SUPERVISOR CERTIFICATION

a. SIGNATURE

b. DATE SIGNED *(YYMMDD)*

COPY TO: EMPLOYEE (LEAVE RECIPIENT)
COMPONENT ADMINISTRATIVE/EXECUTIVE OFFICER
CIVILIAN PERSONNEL OFFICE
CIVILIAN PAYROLL OFFICE