

<b>VOLUNTARY LEAVE TRANSFER PROGRAM NOTICE OF TERMINATION OF MEDICAL EMERGENCY</b>			<b>1. PAYBLOCK NUMBER</b>
<b>2. LEAVE RECIPIENT</b>			
a. NAME ( <i>Last, First, Middle Initial</i> )		b. SOCIAL SECURITY NO.	
c. ORGANIZATION			
<b>3. LEAVE DATA</b>			<b>4. DATE OF TERMINATION OF MEDICAL EMERGENCY (YYMMDD)</b>
a. DATE TRANSFERRED LEAVE BEGAN ( <i>YYMMDD</i> )	b. NUMBER OF HOURS OF LEAVE TRANSFERRED	c. NUMBER OF HOURS OF TRANSFERRED LEAVE USED	
<b>5. REMARKS</b>			
<b>6. SUPERVISOR CERTIFICATION</b>			
a. SIGNATURE			b. DATE SIGNED ( <i>YYMMDD</i> )
COPY TO: EMPLOYEE (LEAVE RECIPIENT) COMPONENT ADMINISTRATIVE/EXECUTIVE OFFICER		CIVILIAN PERSONNEL OFFICE CIVILIAN PAYROLL OFFICE	