

AIR FORCE NON-APPROPRIATED FUND EMPLOYEE TRANSFER ASSISTANCE PROGRAM APPLICATION

EMPLOYEE INFORMATION	
Name: (Last Name, First Name)	Date Requested
Employment Category:	Position Title: (Title, Pav Plan, Series, Grade)
Phone Number :	Personal Email: (Must be Valid During Transfer Period)

TRANSFER REQUEST		
Current Duty Station	Desired Duty Station	
Installation:	Installation:	
CYS Program Area:	CYS Program Area:	
Age Group:	Desired Age Group:	
Current Schedule:	Desired Schedule:	
Last Day of Work (Losing):	Report No Later Than Date (Gaining):	Anticipated Start Date (if different than NLT date):

_____ I understand program eligibility must be met at the time of the application and if I fail to maintain eligibility at any time during the process, I will be removed from the program.

_____ I agree to take uninterrupted leave not to exceed 150 consecutive days (e.g., paid, unpaid, combination) during the transfer period to out-process from my current Air Force Duty Station and report to my new assigned Duty Station.

_____ If additional leave is needed, I understand a separate Leave Request, justifying the need for the extension must be submitted for approval to the local HR prior to my departure.

_____ I understand my salary will not decrease, however I may be offered a position within a different employment category, which I can accept or decline. Declination of a lesser employment category will not result in removal from this program.

_____ Information regarding pay, leave, and eligibility should be directed to your current HR office.

My signature and submission of this application affirms my intent of voluntarily participation in the Air Force NAF Employee Transfer Assistance Program. I agree to all above terms and further understand this process does not guarantee continued employment.

Employee Signature

(For Internal Use Only)

ELIGIBILITY VERIFICATION: CYP MANAGEMENT	
<input type="checkbox"/> Request for Leave or Approved Absence (Attached) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
_____	_____
Supervisor Signature	Date

ELIGIBILITY CERTIFICATION: LOSING HUMAN RESOURCES OFFICE	
Performance Rating Verification:	Disciplinary Action Verification:
Rating Date:	Action Processed
Rating of Record:	Yes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
BCR form received: <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
_____	_____
Human Resources Signature	Date