



Request for or Notification of Absence

Employee's Name (Print last, first, MI)		Employee ID	Date Submitted (MM/DD/YYYY)	No. of Hours Requested		SCHEDULED UNSCHEDULED	PP	Year	
Installation (For postmaster's leave, show city, state, and ZIP Code)		N/S Day	Pay Loc. No.	D/A Code	From: Date				Hour
Time of Call or Request	Scheduled Reporting Time	If Needed, Employee Can Be Reached At:		Thru: Date	Hour				
Type of Absence		Documentation (For official use only)		Revised Schedule for (Date)	Approved in Advance		Day	Init.	Hours
<input type="checkbox"/> Annual <input type="checkbox"/> Holiday/AL Lv Exch <input type="checkbox"/> Carrier 701 Route <input type="checkbox"/> LWOP (See reverse) <input type="checkbox"/> Sick (See reverse) <input type="checkbox"/> Late <input type="checkbox"/> COP (See reverse) <input type="checkbox"/> Other _____		<input type="checkbox"/> FMLA Requested (Certification review - HRSSC) <input type="checkbox"/> For COP Leave (CA1 on file) <input type="checkbox"/> For Advanced Sick Leave (PS 1221 on file) <input type="checkbox"/> For Military Leave (Orders reviewed) <input type="checkbox"/> For Court Leave (Summons reviewed) <input type="checkbox"/> For Higher Level (PS 1723 on file) <input type="checkbox"/> Scheme Training Testing Qualifying (Memo on file)		<input type="checkbox"/> Do not call Begin Work Lunch Out Lunch In End Work Total Hours	<input type="checkbox"/> Yes <input type="checkbox"/> No		Sat 01		
Remarks (Do not enter medical information. See Privacy Act Statement on reverse of this form.)									
I understand that the annual leave authorized in excess of the amount available to me during the leave year will be charged to LWOP.									
Employee's Signature and Date			Signature of Person Recording Absence and Date			Signature of Supervisor and Date Notified			
Official Action on Application (Return copy of signed request to employee.)									
<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved (Give reason below)			Do not check an FMLA box until you verify the FMLA designation. <input type="checkbox"/> FMLA Designation is PENDING <input type="checkbox"/> FMLA Protected <input type="checkbox"/> Not FMLA Protected			Signature of Supervisor and Date <input type="checkbox"/> Continued on reverse			
							Sun 09		
							Mon 10		
							Tue 11		
							Wed 12		
							Thur 13		
							Fri 14		

Reason I was incapacitated for duty during this absence: <input type="checkbox"/> Sickness <input type="checkbox"/> On-the-Job Injury <input type="checkbox"/> Off-the-Job Injury <input type="checkbox"/> Exposed to a Contagious Disease <input type="checkbox"/> Pregnancy, Prenatal Care, or Childbirth <input type="checkbox"/> Undergoing Medical, Dental, or Optical Examination or Treatment (Job-related) <input type="checkbox"/> Undergoing Medical, Dental, or Optical Examination or Treatment (Not job-related)				Leave Types and Codes (Information Only) Annual 55 Annual - FMLA 55 01 05599 Sick 56 Sick - FMLA 56 02 05699 Sick - Dependent Care 56 08 05697 Sick - Dependent Care - FMLA 56 07 05698 Absent Without Leave 24 Act of Nature 78 07800 Blood Donor 69 06900 Civil Defense 77 07700 Civil Disorder 81 08100 COP - USPS 71 07100 COP - USPS - FMLA 71 03 07199 Court Duty 61 06100 Donated 45 04500 Donated - FMLA 46 04600 HQ Authorized Administrative 79 07900 Holiday - AL Leave Exchange 28 02800 LWOP - Part Day 59 05900 LWOP - Part Day - FMLA 59 05 05999 LWOP - Full Day 60 06000 LWOP - Full Day - FMLA 60 06 06999 LWOP - IOD/OWCP 49 04900 LWOP - IOD/OWCP - FMLA 49 04 04999 LWOP - In Lieu of Sick Leave 59 or 60 05901 or 06001 LWOP - Maternity 59 or 60 05905 or 06005 LWOP - Military 44 04400 LWOP - Personal Reasons 59 or 60 05903 or 06003 LWOP - Proffered 59 or 60 05902 or 06002 LWOP - Suspension 59 or 60 05906 or 06006 LWOP - Suspension Pend Term 59 or 60 05908 or 06008 LWOP - Union Official 84 08400 Military 67 06700 Relocation 80 08000 Voting Leave 85 08500 Other Paid Leave 86 08600			Time Card FMLA Dep. Care Time Clock		SCHEDULED UNSCHEDULED	PP	Year
Reason I was/will be unavailable for duty during this absence: <input type="checkbox"/> Sick Leave for Dependent care (See ELM) <input type="checkbox"/> Birth of a Child/Bonding <input type="checkbox"/> To Care for a Family Member (See ELM) <input type="checkbox"/> Placement of a Child With Employee for Adoption or Foster Care <input type="checkbox"/> A Military Family Member's Qualifying Exigency <input type="checkbox"/> To Care for an Injured or Ill Military Family Member						Day	Init.	Hours			
I am requesting Family and Medical Leave Act (FMLA) protection for this absence: <input type="checkbox"/> This request is associated with a new condition. (You will receive an FMLA packet in the mail with forms and instructions.) <input type="checkbox"/> My approved or pending approval case number for this condition is: _____ Employee must not be asked to disclose personal medical information to local management. FMLA certification must be mailed to HRSSC.						Sat 01					
Additional Documentation Required as follows:						Sun 02					
Privacy Act Statement: Your information will be used to administer leave. Collection is authorized by 39 USC 401, 404, 1001, 1003, and 1005; and 29 USC 2601 et seq. Providing the information is voluntary, but if not provided, we may not process your request. Your information may be disclosed as follows: in relevant legal proceedings; to law enforcement when the USPS or requesting agency becomes aware of a violation of law; to a congressional office at your request; to entities under contract with USPS and/or authorized to perform audits; to labor organizations as required by law; to government agencies regarding personnel matters; and to the EEOC; MSPB or Office of Special Counsel.						Mon 03					
						Tue 04					
						Wed 05					
						Thur 06					
						Fri 07					
						Sat 08					
						Sun 09					
						Mon 10					
						Tue 11					
						Wed 12					
						Thur 13					
						Fri 14					