



# Request for or Notification of Absence

Employee's Name (Print last, first, MI.)		Employee ID	Date Submitted (MM/DD/YYYY)	No. of Hours Requested		<b>SCHEDULED</b>	<b>UNSCHEDULED</b>	PP	Year
Installation (For postmaster's leave, show city, state, and ZIP Code)		N/S Day	Pay Loc. No.	D/A Code	From: Date				
Time of Call or Request	Scheduled Reporting Time	If Needed, Employee Can Be Reached At:		Thru: Date	Hour			Day	Init.
		<input type="checkbox"/> Do not call							
Type of Absence	Documentation (For official use only)	Revised Schedule for (Date)		Approved in Advance					
<input type="checkbox"/> Annual	<input type="checkbox"/> FMLA Requested (Certification review - HRSSC)	Begin Work		<input type="checkbox"/> Yes <input type="checkbox"/> No		Sat 01			
<input type="checkbox"/> Holiday/AL Lv Exch	<input type="checkbox"/> For COP Leave (CA1 on file)	Lunch Out		Lunch In		Sun 02			
<input type="checkbox"/> Carrier 701 Route	<input type="checkbox"/> For Advanced Sick Leave (PS 1221 on file)	End Work				Mon 03			
<input type="checkbox"/> LWOP (See reverse)	<input type="checkbox"/> For Military Leave (Orders reviewed)	Total Hours				Tue 04			
<input type="checkbox"/> Sick (See reverse)	<input type="checkbox"/> For Court Leave (Summons reviewed)					Wed 05			
<input type="checkbox"/> Late	<input type="checkbox"/> For Higher Level (PS 1723 on file)					Thur 06			
<input type="checkbox"/> COP (See reverse)	<input type="checkbox"/> Scheme Training Testing Qualifying (Memo on file)					Fri 07			
<input type="checkbox"/> Other _____						Sat 08			
Remarks (Do not enter medical information. See Privacy Act Statement on reverse of this form.)						Sun 09			
<b>I understand that the annual leave authorized in excess of the amount available to me during the leave year will be charged to LWOP.</b>						Mon 10			
Employee's Signature and Date		Signature of Person Recording Absence and Date		Signature of Supervisor and Date Notified		Tue 11			
						Wed 12			
<b>Official Action on Application (Return copy of signed request to employee.)</b>						Thur 13			
<input type="checkbox"/> Approved		Do not check an FMLA box until you verify the FMLA designation.		Signature of Supervisor and Date		Fri 14			
<input type="checkbox"/> Disapproved (Give reason below)		<input type="checkbox"/> FMLA Designation is PENDING							
		<input type="checkbox"/> FMLA Protected							
		<input type="checkbox"/> Not FMLA Protected		<input type="checkbox"/> Continued on reverse					

<b>Reason I was incapacitated for duty during this absence:</b>				<b>Leave Types and Codes</b> (Information Only)	<b>Time Card</b>	<b>FMLA Dep. Care</b>	<b>Time Clock</b>	<b>SCHEDULED</b>	<b>UNSCHEDULED</b>	PP	Year	
<input type="checkbox"/> Sickness	<input type="checkbox"/> Undergoing Medical, Dental, or Optical Examination or Treatment (Job-related)	<input type="checkbox"/> On-the-Job Injury	<input type="checkbox"/> Off-the-Job Injury	Annual	55		05500					Day
<input type="checkbox"/> Exposed to a Contagious Disease	<input type="checkbox"/> Undergoing Medical, Dental, or Optical Examination or Treatment (Not job-related)	<input type="checkbox"/> Pregnancy, Prenatal Care, or Childbirth		Annual - FMLA	55	01	05599			Sat 01		
<b>Reason I was/will be unavailable for duty during this absence:</b>				Sick	56		05600					
<input type="checkbox"/> Sick Leave for Dependent care (See ELM)	<input type="checkbox"/> Placement of a Child With Employee for Adoption or Foster Care	<input type="checkbox"/> Birth of a Child/Bonding	<input type="checkbox"/> A Military Family Member's Qualifying Exigency	Sick - FMLA	56	02	05699					
<input type="checkbox"/> To Care for a Family Member (See ELM)	<input type="checkbox"/> To Care for an Injured or Ill Military Family Member			Sick - Dependent Care	56	08	05697					
<b>I am requesting Family and Medical Leave Act (FMLA) protection for this absence:</b>				Sick - Dependent Care - FMLA	56	07	05698					
<input type="checkbox"/> This request is associated with a new condition. (You will receive an FMLA packet in the mail with forms and instructions.)				Absent Without Leave	24		02400					
<input type="checkbox"/> My approved or pending approval case number for this condition is:				Act of Nature	78		07800					
Employee must not be asked to disclose personal medical information to local management. FMLA certification must be mailed to HRSSC.				Blood Donor	69		06900					
<b>Additional Documentation Required as follows:</b>				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		00500					
				Voting Leave	85		08500					
				Other Paid Leave	86		08600					