File Number:
ff-O-NO

U.S. DEPARTMENT OF LABOR

DFELHWC-FECA, PO Box 8311
LONDON, KY 40742-8311
Phone: (202) 513-6860

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July 11, 2022

Date of Injury:
Employee:

DAVID MILLER
NALC
12015 E 46TH AVE SUITE 550
DENVER, CO 80239

Dear DAVID MILLER:

This is in response to your request for clarification on 05/13/2022. If a claimant is only capable of working 4 hours, he is entitled to those 4 hours he couldn't work anyway. We still pay the 4 hours of LWOP because he would not have been able to work those hours regardless. The claimant will have to use annual leave for the other 4 hours.

Sincerely,

Federal Employees Program

Cc:
UNITED STATES POSTAL SERVICE
AR-OK
OCCUPATIONAL HEALTH CLAIMS OFFICE
4025 W RENO AVE
OKLAHOMA CITY, OK 73125

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodation(s) and/or modification(s), please contact OWCP.

UNITED STATES POSTAL SERVICE®

Request for or Notification of Absence

Employee's Name *(Print last, first, MI.)*	Employee ID	Date Submitted *(MM/DD/YYYY)*	No. of Hours Requested
			80.00

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: ☐ Do not call	Thru: Date / Hour

Type of Absence
- ☒ Annual
- ☐ Holiday/AL Lv Exch
- ☐ Carrier 701 Route
- ☒ LWOP *(See reverse)*
- ☐ Sick *(See reverse)*
- ☐ Late
- ☐ COP *(See reverse)*
- ☐ Other _____

Documentation *(For official use only)*
- ☐ FMLA Requested *(Certification review – HRSSC)*
- ☐ For COP Leave *(CA1 on file)*
- ☐ For Advanced Sick Leave *(PS 1221 on file)*
- ☐ For Military Leave *(Orders reviewed)*
- ☐ For Court Leave *(Summons reviewed)*
- ☐ For Higher Level *(PS 1723 on file)*
- ☐ Scheme Training Testing Qualifying *(Memo on file)*

Revised Schedule for *(Date)*	Approved in Advance ☐ Yes ☐ No
Begin Work	
Lunch Out	Lunch In
End Work	
Total Hours	

Remarks *(Do not enter medical information. See Privacy Act Statement on reverse of this form.)*

40 hours of annual leave and 40 hours of LWOP-049 per 4 hour job offer.

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.)***

- ☐ Approved
- ☐ Disapproved (Give reason below)

Do not check an FMLA box until you verify the FMLA designation.
- ☐ FMLA Designation is PENDING
- ☐ FMLA Protected
- ☐ Not FMLA Protected

Signature of Supervisor and Date

☐ ***Continued on reverse***

SCHEDULED	UNSCHEDULED	PP	Year		
		Day	Init.	Hours
		Sat 01		
		Sun 02		
		Mon 03		
		Tue 04		
		Wed 05		
		Thur 06		
		Fri 07		
		Sat 08		
		Sun 09		
		Mon 10		
		Tue 11		
		Wed 12		
		Thur 13		
		Fri 14		

Warning: The furnishing of false information on this form may result in a fine of not more than $10,000 or imprisonment of not more that 5 years, or both *(18 U.S.C. 1001).*

Reason I was incapacitated for duty during this absence:
- ☐ Sickness
- ☐ On-the-Job Injury
- ☐ Off-the-Job Injury
- ☐ Exposed to a Contagious Disease
- ☐ Pregnancy, Prenatal Care, or Childbirth
- ☐ Undergoing Medical, Dental, or Optical Examination or Treatment *(Job-related)*
- ☐ Undergoing Medical, Dental, or Optical Examination or Treatment *(Not job-related)*

Reason I was/will be unavailable for duty during this absence:
- ☐ Sick Leave for Dependent care *(See ELM)*
- ☐ Birth of a Child/Bonding
- ☐ To Care for a Family Member *(See ELM)*
- ☐ Placement of a Child With Employee for Adoption or Foster Care
- ☐ A Military Family Member's Qualifying Exigency
- ☐ To Care for an Injured or Ill Military Family Member

I am requesting Family and Medical Leave Act (FMLA) protection for this absence:
- ☐ This request is associated with a new condition. *(You will receive an FMLA packet in the mail with forms and instructions.)*
- ☐ 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.

Additional Documentation Required as follows:

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.

Leave Types and Codes (Information Only)	Time Card	FMLA Dep. Care	Time Clock
Annual	55		05500
Annual – FMLA	55	01	05599
Sick	56		05600
Sick – FMLA	56	02	05699
Sick – Dependent Care	56	08	05697
Sick – Dependent Care – FMLA	56	07	05698
Absent Without Leave	24		02400
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		00500
Voting Leave	85		08500
Other Paid Leave	86		08600

SCHEDULED	UNSCHEDULED	PP	Year		
		Day	Init.	Hours
		Sat 01		
		Sun 02		
		Mon 03		
		Tue 04		
		Wed 05		
		Thur 06		
		Fri 07		
		Sat 08		
		Sun 09		
		Mon 10		
		Tue 11		
		Wed 12		
		Thur 13		
		Fri 14		

Time Analysis Form

U.S. Department of Labor
Office of Workers' Compensation Programs

Employee Statement - Please carefully read instructions on reverse *before* filling out this form.

1. Name of Employee: (*Last, First, Middle*)	2. SSN	3. OWCP File Number

4. Period Covered by This Form:	5. Total Hours Claimed
From: To:	for LWOP:
	for Leave BuyBack:

6. In "Type of Leave Used" column, use codes "S" = Sick, "A" = Annual, "O" = Other. If Compensation is claimed for date, indicate "Yes" in "Compensation Claimed" column.

Date(s)	Compensation Claimed?	Number of Hours				Type of Leave Used	Reason for Leave Use/Remarks (e.g., doctor visit, therapy, etc.)
		LWOP	Worked	Hol	Leave		
04/14/2024	YES	4			4	Annual	4 hour job offer
Totals		4			4		

Signature of Claimant — Date Signed

7. Agency Statement/Certification: I certify the above is accurate, except as follows:

Signature of Agency Official — Date Signed