UNITED STATES POSTAL SERVICE®

Treatment Verification for Wounded Warriors Leave

A. Employee Information (To be completed by the employee)

Name (Last, First, Middle Initial)	Employee ID	Date Submitted
Installation	**Date of Appointment with Health Care Provider**	**Time of Appointment with Health Care Provider**

I certify that I am requesting Wounded Warriors Leave in conjunction with a military service-connected disability rated at 30 percent or more. I have provided documentation to the Postal Service from the Department of Veterans Affairs, or on any Office of Personnel Management (OPM) certification form developed for administration of Wounded Warriors Leave, certifying that I have a qualifying service-connected disability, as required in Management Instruction EL-510-2016-8.

I also acknowledge that I have **15 calendar days** from the date I return to work to provide this verification to the appropriate supervisor to use Wounded Warriors Leave in lieu of sick leave, annual leave, or leave without pay.

Employee Signature	Date

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; to the EEOC; and to the MSPB or Office of Special Counsel. For more information regarding our privacy policies visit *www.usps.com/privacypolicy.*

B. Provider Information (To be completed by the health care provider)

Name of Physician/Provider	Specialty
Name of Health Care Facility	**Contact Telephone Number**

Please provide details of any treatment required, including the frequency and/or duration of any course of action you may prescribe, that would necessitate the employee taking additional leave from work beyond the date of appointment identified in the *Employee Information* portion of this verification form.

The above-referenced employee is requesting to take leave under the Wounded Warriors Federal Leave Act of 2015 for treatment of a service-connected disability, as certified by the U.S. Department of Veterans Affairs. Treatment is defined as an in-person visit to a health care provider and includes the course of action prescribed by a health care provider. Your signature below, as the health care provider, verifies that the identified employee is undergoing treatment for a certified disabling condition.

Health Care Provider Signature	Date

Printed Name

C. Official Action on Application (Return copy of signed request to employee)

☐ Approved ☐ Disapproved

Reason/Reason Code for disapproval (if applicable):

Supervisor Signature	Date