REQUEST FOR INJURED WITH PAY

Employee's Statement:

I, _____, _____ , _____
(name) (classification) (jurisdiction)
request for injured with Pay/Extension of Injured with Pay for the period _____ through _____ as confirmed by the physician's statement below. Such leave is requested for the purpose of convalescence from an injury received while on duty_____. A description of how said injury occurred is as follows:

_____
_____
_____
_____
_____
_____
_____

_____ _____
(Employee's Signature) (Date)

APPROVED BY: ☐ _____ _____
(Date) (Human Resources/Appointing Authority's Signature)

Physician's Statement:

Being a duly licensed health provider in the State of Alabama, I _____, began treatment for the above mentioned individual on _____.

It is my judgment that said employee is unable, due to his/her injury, to assume duties of his/her employment at this time.

Anticipated date of recovery/ability to return to work is _____.

_____ _____
(Date) (Signature)

(Other forms of physician's certificate containing all of the above mentioned information will serve as suitable substitutes of this portion of the form when attached.)

APPROVED:

_____ _____
(Date) (Civil Service Director or Designee)