REQUEST FOR INJURED WITH PAY

Employee's Statement:

I, ________________________________, _________________________, _______________, _________________
(name) (classification) (jurisdiction) (department)
hereby 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:

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____________________________ ___________ ___________________________ __________
(Employee's Signature) (Date) (Supervisor's Signature) (Date)

APPROVED BY: ☐ ______________ ___________________________________
(Date) (Department Head's Signature)

☐ ______________ ___________________________________
(Date) (Human Resources/Appointing Authority's Signature)

Physician's Statement:

Being a duly licensed physician in the State of Alabama, I ___________________________________, began treatment for the above mentioned individual on ______________________. A brief summary of the nature and extent of the injury is as follows:

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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) (Physician's 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 hereby attached.)

APPROVED:

______________ ___________________________________
(Date) (Director or Assistant Director)