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:

_____
_____
_____
_____
_____
_____
_____

_____ _____ _____ _____
(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:

_____
_____
_____
_____

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) (Civil Service Director or Designee)