

Request for Assault Leave

I hereby certify that I have been physically disabled from performing my duties as a result of the described assault which occurred in the course of my employment.

Medical attention was required.

(If checked, have physician complete below.)

Medical attention was not required.

▲ I understand that falsification, of either this signed statement or the physician's certificate, is grounds for suspension or termination of employment under Section 3319.16 of the Ohio Revised Code.

Date

Employee's Signature

▲ I have investigated this matter and attest to the fact that this employee was assaulted.

Date

Principal's Signature

▲ Date(s) of Absence _____

Physician's Form

This is to certify that

Employee's Name - Print

Has been under my professional care because of

Anticipated date for return to work is _____

Date

Physician's Signature

HR 1/98

Distribution: (Original) Director, Human Resources

(Copies) _____ Principal, _____ Employee, _____ Union