GADSDEN STATE COMMUNITY COLLEGE
PAID ABSENCES DUE TO ON-THE-JOB INJURIES

- **Salary continuation for absences due to an on-the-job injury may be made only for temporary disabilities where there is a reasonable expectation of the employee's return to work.**
- **In no event shall the salary and benefits continuation exceed the equivalent of ninety (90) working days.**
- **Accrued leave shall not be deducted from the employee's account if absence from work results from an on-the-job injury. Up to ninety (90) days of leave may be reinstated if previously deducted and later approved under this policy.**
- **Number of days/hours to be reinstated _____.**

I have reviewed the attached Application for Salary Continuation for Absence Due To On-The-Job Injury. After review of Board Policy 610.02 and Procedures, I recommend approval of this application.

_____ _____
Immediate Supervisor **Date**

_____ _____
Cabinet Member **Date**

Approved:

_____ _____
President **Date**

APPLICATION FOR SALARY CONTINUATION FOR ABSENCE
DUE TO JOB-RELATED INJURY

This form should be completed by the injured employee or in the event the employee is not clinically able to complete and submit this application, by a representative of the employee. Such individual must be reasonably knowledgeable concerning the injury and the condition of the employee.

Name of Injured Employee: _____

Social Security Number: _____

Title or Position of Employee:_____

Specific Location at Which Injury Occurred: _____

Date and Time of Injury:_____

Name of Witnesses to the Injury: (NOTE: If there were no witnesses to the injury, the employee must have their statement notarized below.)

_____

_____

State in detail how your injury occurred: _____

_____

_____

State all factors which contributed to your injury: _____

_____

_____

Describe the nature and extent of your injury:_____

_____

_____

_____ _____

Signature of Employee Date

STATE OF _____, COUNTY OF _____

BEFORE ME, the undersigned Notary Public, personally appeared _____, who is known to me, and being duly sworn, conformed on the _____ day of _____, 20____,that the information contained hereinabove is true, accurate, and complete the best of his/her knowledge and information.

Signature of Notary Public _____

My Commission Expires _____

Revised May 2019

PHYSICIAN'S STATEMENT

(Necessary if employee is requesting payment for an absence of more than three (3) working days or if the injury arising from job-related stress)

Diagnosis: _____

_____

_____

_____

_____

Treatment: _____

_____

_____

_____

_____

Prognosis: _____

_____

_____

_____

_____

Estimated Date for Return to Work: _____

_____ _____

Signature of Physician Date

Office Address of Physician: _____

_____

Telephone: _____

Revised May 2019