



**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 to 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: _____

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