



REQUEST FOR LEAVE OF ABSENCE WITH PAY DUE TO INJURY

Employee name:		Mailing address (work):		Classification:	
Agency:		Employing unit:		Headquarters city:	
Location where injury occurred:			Time of injury:		Date of injury:
Worker's compensation claim filed? ___ Yes ___ No		Probable duration of disability:			
Has a previous request for 230.36 benefits been filed for this injury? ___ Yes ___ No					
Describe nature of injury:					
Describe circumstances resulting in the injury:					
If injury involved other persons, give names and indicate whether employee, patient, inmate, or other:					
Names and addresses of witnesses:					
Attending physician's name and address:					
I certify that to the best of my knowledge these statements are true and that the injury was incurred in the performance of my duties. If benefits are denied, I understand that if I am an employee covered by a collective bargaining agreement, I may appeal in accordance with applicable agreement provisions. I further understand that if I am an employee not covered by a collective bargaining agreement, I may file a grievance in accordance with Wisconsin Human Resources Handbook Chapter 430.030 within 30 days of the date of the decision.					
Date:		Signature of employee:			
SECONDARY LEVEL RECOMMENDATION: ___ Approved ___ Denial of benefits – If denial is recommended, state reasons:					
I certify that I have investigated/reviewed this request.					
Date:		Signature of authorized representative:			
AGENCY ACTION: ___ Approved ___ Denied – If denied, state reasons:					
Date:		Signature of appointing authority:			

DISTRIBUTION: ___ Employee P-File ___ DPM ___ Agency ___ Secondary Level ___ Employee