**Employee Request for Assault Leave**

Please complete this form and return to [benefits@pisd.edu](mailto:benefits@pisd.edu)

**Employee Name:** Click or tap here to enter text.

**ID #:**  Click or tap here to enter text.

**School/Department:** Click or tap here to enter text.

**Position Title:** Click or tap here to enter text.

**Date of Injury:** Click or tap here to enter text.

* Please describe the details of the incident, what occurred, the injuries you sustained, and any other information for the committee to review:

Click or tap here to enter text.

* Have you seen a doctor for this work-related injury?

Click or tap here to enter text.

If yes, the DWC 73 form(s) completed by the doctor will be reviewed with your request for assault leave. For absences of 3 days or longer, medical certification is required to document your inability to work due to physical injuries.

* If your absence was only 1 or 2 days, and you did not see a doctor for this injury, please provide explanation of your inability to work:

Click or tap here to enter text.

**Employee Signature Date**