REQUEST FOR LEAVE OF ABSENCE WITH PAY DUE TO INJURY

Employee name:	Email address (work):	Classification:	
UW System institution:	Department or office:		
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 hazardous employment 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 the injured person is also an employee:			
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.			
Date:	Signature of employee:		
SUPERVISOR'S RECOMMENDATION TO APPROVE OR DENY THE BENEFITS : ___Approve ___Deny – If denial is recommended, state the reasons in an attachment.			
I certify that I have investigated/reviewed this request.			
Date:	Signature of the Employee's Supervisor:		
FINAL DECISION: ___Approved ___Denied – If denied, state the reasons in an attachment.			
Date:	Signature of the Chancellor or the Chancellor's designee:		

Submit completed form to: UW System Office of Risk Management, 780 Regent Street, Madison, WI 53715