

CITY OF CORAL GABLES
DEPARTMENT OF HUMAN RESOURCES
DISABILITY LEAVE REQUEST FORM

In accordance with Rule 14 of the City's Personnel Rules & Regulations, if you sustain an on-the-job injury covered by workers compensation insurance, you may be entitled to disability leave pay. A statement from the attending physician is required and it must indicate the nature of the injury and cover the employee's period of absence. The leave application and the physician statement must be submitted within 21 calendar days after the date of accident.

Employee Name:	Dept./Division:	
Employee No.:	Position:	Date of Request:
Full Time Employee: Yes No		
Date of injury or illness:		
Was disability due to an on-the-job injury or illness? Yes No		
Did your supervisor complete a First Report of Injury form? Yes No		
Requested Disability Start Date: _____ Anticipated Return Date: _____		
Medical Appointment Physical Therapy Diagnostic Test Other: _____		
Employee Signature: _____		Date: _____
Approval by Human Resources Director: Approved Denied		
Signature: _____		Date: _____