ASSAULT LEAVE APPLICATION/QUALIFICATION GUIDELINES/QUESTIONAIRE

First Name:	Last Name:	EIN:	Employment Status:
Position/Job Title:	Supervisor's Name:	Location:	Date of Incident:
Contact Number:	First Date of Disablement:	Workers' Comp. Claim #"	

Department or Location Assault Occurred:

Please give a sequence of events that directly lead to the assault:

Was the unprovoked assault reported to the principal or immediate supervisor prior to the close of school or work day? Yes or No (If yes, please list the person or persons name the incident was reported to.)

Was a security incident report completed and filed with the Department of School Security? Yes or No (If yes, please submit a copy of the security incident report.)

Was the local law enforcement agency contacted upon the incident's occurrence? (If yes, please provide a copy of the law enforcement report or case number)

The Board of Education employee must receive medical treatment with a physician or emergency room at a hospital within forty-eight hours of the incident, please provide the name and location where medical treatment was given.

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Fraud Statement: It is a crime and against PGCPS policy to provide false or misleading information for the purposes of defrauding PGCPS or any other person. Penalties may include imprisonment, fines or termination of employment. Additionally, PGCPS may deny benefits if the false information materially related to the employ claim were provided by the employee.

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Employee's Signature Date