

City of El Paso
Human Resources Department
Accident with Pay Leave Request
PART I – EMPLOYEE'S REQUEST

(Type or Print in Ink)

To: DEPARTMENT HEAD	DEPARTMENT:
From: (EMPLOYEE LAST, FIRST, MIDDLE INITIAL)	EMPLOYEE ID NUMBER:
<p>Under the provisions of Section 4.5, City Ordinance 8064 (Amended 08/27/98), I hereby request Accident With Pay Leave. This request is based upon my job-related injury (or illness) which occurred on: _____ (date) at _____ M (time). I reported my injury (or illness) to my supervisor, _____ (name) on _____ (date) at _____ M (time). I have attached the required medical report from my treating physician indicating that any lost time is due to my job-related injury (or illness). I understand that I must request AWP leave for each additional period of absence, and must provide a medical report for the corresponding amount of days or hours of AWP leave requested with each AWP Leave Request.</p> <p>I understand that for the initial (7) days of lost time, I will not receive AWP leave I ELECT/DO NOT ELECT (circle one) to use my accrued sick leave/annual leave during the initial seven days of disability. I further understand and agree that in the event of any overpayment of workers' compensation benefits or AWP supplement, the City may deduct the overpayment from future paychecks or reduce any accrued leave balances.</p>	
Employee Signature:	Date:

PART II – DEPARTMENT HEAD'S RECOMMENDATIONS

To: HUMAN RESOURCES DIRECTOR	
From: DEPARTMENT HEAD'S NAME	DEPARTMENT:
Recommend APPROVAL of AWP leave <input type="checkbox"/>	
Recommend DENIAL of AWP leave: <input type="checkbox"/>	
Based upon the following reason(s) – check applicable box(es):	
<input type="checkbox"/> 24-hour reporting requirement not met.	
<input type="checkbox"/> Physician's report not submitted.	
<input type="checkbox"/> Violation of rule/regulation/law/City safety rule/Dept. mandated procedure/Failure to use safety equipment.	
<input type="checkbox"/> Other:	
DEPARTMENT HEADS SIGNATURE:	DATE:
GIVE A COPY OF THIS RECOMMENDATION TO THE EMPLOYEE:	
A. IN PERSON	
EMPLOYEE'S SIGNATURE :	DATE:
B. BY CERTIFIED MAIL:	
CERTIFIED MAIL RETURN RECEIPT REQUEST NUMBER:	DATE:

IF YOUR REQUEST HAS BEEN DENIED, YOU HAVE FIVE (5) DAYS FROM RECEIPT TO APPEAL THIS RECOMMENDATION TO THE DIRECTOR OF HUMAN RESOURCES.