ATTACHMENT A

CITY OF PETERSBURG
LEAVE SHARE PROGRAM

RECIPIENT APPLICATION FORM

This form is to be completed and submitted to the Human Resources Department for consideration. Please refer to the administrative regulation for Leave Share for further instructions.

NAME: _____

DATE: _____ SSN: _____

HOME ADDRESS: _____

_____

WORK PHONE: _____ HOME PHONE: _____

DEPARTMENT: _____

DIVISION: _____

REASON FOR LEAVE REQUEST: _____

_____

_____

ESTIMATED LENGTH OF ABSENCE: _____

I understand the Leave Share regulations and agree to abide by the procedures discussed in that document. I understand I must submit this form and medical documentation to the Human Resources Director.

APPLICANT'S SIGNATURE: _____ DATE: _____

----------FOR HUMAN RESOURCES DEPARTMENT ONLY----------

APPROVED: _____ DATE: _____

DENIED: _____ DATE: _____

REASON FOR DENIAL: _____

_____

_____

_____

CLASSIFICATION AND PAY GRADE: _____

8/00

ATTACHMENT B

PHYSICAL CAPABILITIES FORM

Employee's Name: _____

Nature of Employee's Condition: _____

_____

_____

_____

_____

Expected Work Return Date: _____

Patient May Return to Work: _____ Regular _____ Restricted

Specify Work Restrictions: _____

_____

_____

_____

Length of Restriction: _____

Anticipated Release Date: _____

I hereby certify that all entries and attachments are true and complete.

_____
PHYSICIAN'S NAME (PLEASE PRINT)

_____ _____
PHYSICIAN'S ORIGINAL SIGNATURE DATE

8/00