



# Human Resources Division

## INJURY LEAVE RECORD



<b>SURNAME</b>		<b>FIRST NAMES</b>	
<b>DEPARTMENT</b>		<b>DIVISION</b>	

<b>REQUEST TYPE</b>	<input type="checkbox"/> Work injury <input type="checkbox"/> Non Work injury
---------------------	---

A) IF FULL TIME	
<b>First day absent</b>	<b>Last day absent</b>
<b>TOTAL WORKING DAYS ABSENT</b>	

A) IF PART TIME: For week ending			
DAY	DATE	NORMAL DAILY HOURS	HOURS ABSENT THROUGH SICKNESS
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			

<input type="checkbox"/>	<b>Medical Certificate attached</b> <i>Medical certificate must be attached for any absence in excess of five working days, or less in certain circumstances</i>
<input type="checkbox"/>	<b>Work Injury Report completed</b> <i>Accident report must be completed and forwarded to the Health &amp; Safety Office</i>

APPROVALS	
<b>Employee signature:</b>	<b>Date:</b>
<b>Head of Department signature:</b>	<b>Date:</b>
<b>Head of Department name:</b>	<b>Date:</b>
<p><b>Note:</b> Employee may not always be able to sign if still away. Must forward to Payroll Services at the end of each week regardless.</p>	

PAYROLL SERVICES OFFICE USE ONLY			
<b>Emp no:</b>	<b>Entered:</b>	<b>Signature:</b>	<b>Date:</b>
	<b>Checked:</b>	<b>Signature:</b>	<b>Date:</b>