

Application for Assault Pay (AAP)

To Be Completed By Employee
(Please type or print legibly)

Date Submitted: _____

To: Meghan Abate, Director of Labor Relations
District Designated Representative

From: _____
Bargaining Unit Member

Location/School: _____ Date of Assault: _____

First date of lost time due to assault _____

Expected date of return to work _____

Date Employee Report of Assault and Workers Compensation forms were filed with
Principal/Immediate Supervisor _____

Employee's Signature

Date

Union Representative's Signature

Date

Required Attachments: ☐ Related Medical Documentation
☐ Medical Release

cc: Union Office