Cincinnati Public Schools
Department of Human Resources

Request for Assault Leave

I hereby certify that I have been physically disabled from performing my duties as a result of the described assault which occurred in the course of my employment.

☐ Medical attention was required.
(If checked, have physician complete below)

☐ Medical attention was not required

▲ I understand that falsification, of either this signed statement or the physician's certificate, is grounds for suspension of termination of employment under Section 3319.16 of the Ohio Revised Code.

_____ _____
Date Employee's Signature

▲ I have investigated this matter and attest to the fact that this employee was assaulted.

_____ _____
Date Principal's Signature

▲ Date(s) of Absence _____

Physician's Form

This is to certify that _____
Employee's name (print)
has been under my professional care because of

_____

_____

_____

Anticipated date for return to work is _____

_____ _____
Date Physician's Signature

HR 2019
Distribution: (Original) Director, Human Resources
(Copies) _____ Principal _____ Employee _____ Union