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

(Rev. 2/2012)