

ATTACHMENT 2
APPLICATION FOR EXTENSION OF SALARY & BENEFITS

Name: _____

Employee ID Number: _____

Date of Injury: _____

Nature of Injury/Illness: _____

| FACTOR | DESCRIPTION / DATE PROVIDED |
|---|------------------------------------|
| 1. Verification that injured employee is being actively treated for injury | |
| 2. Projection of return-to-work date (cannot exceed six months) | |
| 3. Verify filing of On-the-job Injury Report | |
| 4. Date of 1044 hours of injury leave is/was exhausted | |
| 5. Medical evidence provided by Treating physician | |
| 6. Verification that employee has not reached Maximum Medical Improvement (MMI) | |

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|--|--|
| 7. Verification that occurrence of on-the-job injury or illness is not contested | |
| <u>Police Only:</u> Availability of assignment based on any limitations | |

List any of the above factors that were not satisfactorily met and explain: _____
