

WESTLAKE CITY SCHOOL DISTRICT  
ATTACHMENT V - ASSAULT LEAVE REQUEST

Name \_\_\_\_\_ Date \_\_\_\_\_ School/Department \_\_\_\_\_

I hereby request \_\_\_\_ day(s) of assault leave beginning at \_\_\_\_\_ on \_\_\_\_\_, \_\_\_\_\_,  
time day month  
20\_\_\_\_ and ending at approximately \_\_\_\_\_ on \_\_\_\_\_, 20\_\_\_\_.  
time day month

Date of Injury \_\_\_\_\_ Nature of Injury \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person Causing Assault \_\_\_\_\_  
Description of Assault \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Use back of form if more space is needed

If medical attention was obtained, the following information must be stated:

Name of Physician \_\_\_\_\_  
Office Address \_\_\_\_\_  
\_\_\_\_\_

Falsification of this statement in this request is grounds for suspension or termination of employment.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Principal/Supervisor

\_\_\_\_\_  
Superintendent