Application for Assault Pay (AAP)

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

Date Submitted: ______________________________

To: Elizabeth Camp, RCSD Labor Relations Specialist
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. 5/2009)