SALARY CONTINUATION VERIFICATION FORM

This form is required in order for continued salary (up to 60 working days) to be paid for time missed from work for medical appointments to treat an industrial injury. Efforts should be made to schedule medical appointments in a manner as to avoid as much as possible, disruption to the District's operation.

When medical appointments do occur during work hours, this form should be taken by the injured employee to the medical appointment in order to obtain the physician or therapist's signature. The signed form needs to be forwarded to Sedgwick by fax to *(626) 397-9250* or by mail to *P.O. Box 14623, Lexington, KY 40512* and a copy provided to the work site. Only if Payroll receives this completed form showing authorization by Sedgwick will adjustment from illness time to continued salary be made.

EMPLOYEE INFORMATION (Please print)

Employee's Name	Employee No.
Date of Injury	Claim number
Name of School or Office	Cost Center (Location code)

ADDITIONAL ABSENCES:

Date of Absence	Doctor/Therapist	Appointment Time	Total Hours

CERTIFICATION

Under penalty of perjury the undersigned hereby acknowledges the statements made are true and factual.

Signature of injured employee _____ **Date** _____

Signature of physician or therapist _____ **Date** _____

The periods of absence shown above are hereby certified to be occasioned by authorized appointments related to an accepted, active workers' compensation claim.

Signature of Claims Adjuster _____ **Date** _____

NOTICE: Making a false or fraudulent workers' compensation claim is a felony subject to a maximum of 5 years in prison or a fine of up to $50,000 or double the value of the fraud, whichever is greater, or by both imprisonment and fine.