STATE OF CALIFORNIA

EMPLOYEE — EMPLOYER REPORT OF OCCUPATIONAL INJURY OR ILLNESS

TO BE FILLED OUT BY THE INJURED EMPLOYEE WHENEVER POSSIBLE WITHIN 24 HOURS OF THE INJURY.

EMPLOYER

THE CITY OF SAN DIEGO
DEPARTMENT OF EMPLOYEE SERVICES
202 C STREET
SAN DIEGO, CALIFORNIA 92101
TELEPHONE 236-6395
A MUNICIPAL GOVERNMENT
LEGALLY UNINSURED
EMPLOYER NO. 4-0107-00

WRITE FIRMLY - YOU ARE MAKING FOUR COPIES

FORWARD ORIGINAL AND FIRST THREE COPIES TO THE INSURANCE AND CLAIMS DIVISION

WHITE	-	CLAIMS
GREEN	-	SAFETY MANAGE[MENT]
CANARY	-	STATE OF CALIF[ORNIA]
PINK	-	ORIGINATING DEP[T.] DIV.
GOLDENROD	-	INJURED EMPLOY[EE]

OSHA Case or File No. C

EMPLOYEE

NAME: AVRECH, LARRY SCOTT

7. SOCIAL SECURITY NUMBER: 360-46-2298

8. HOME ADDRESS (number and street, city, Zip): 9863 VIA RITA SANTEE, CALIFORNIA 92071

8A. PHONE NUMBER: 448-8545

9. SEX: [X] Male [ ] Female

10. OCCUPATION (Regular job title, not specific activity at time of injury): POLICE OFFICER RECRUIT

11. DATE OF BIRTH: AGE 27 — 7 / 10 / 52 (Month, Day, Year)

12. DEPARTMENT IN WHICH REGULARLY EMPLOYED: SAN DIEGO POLICE

12A. DATE OF HIRE: 11 / 13 / 79 (Month, Day, Year)

13. WAGES: $ 239.31 per week

HEIGHT: 5-6

WEIGHT: 214

MARITAL STATUS: MARRIED

DRIVERS LICENSE NO.: N3183213

INJURY OR ILLNESS

14. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (address, city and county): 10440 BLACK MT. ROAD SAN DIEGO CA. 92126 POLICE ACADEMY

15. ON CITY PREMISES? [ ] No [X] Yes

16. WHAT WERE YOU DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material you were using.) I WAS PARTICIPATING IN A PHYSICAL TRAINING CLASS AT THE POLICE ACADEMY. DURING THE 440-RELAYS AS I RAN THE FIRST SET A FELT A SHARP PAIN IN THE FRONT OF BOTH LOWER LEGS AS I FINISHED THE RACE I WAS IN A GREAT DEAL OF PAIN AND UNABLE TO STAND FIRM ON THE GROUND. THE PAIN WAS IN THE TIBIA BONE AREA OF THE LEG.

17. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.) THE DAY PREVIOUS TO THE INJURY WE RAN UPHILL FOR THE FIRST TIME. THE TRAINING OFFICER ADVISED THAT WE MIGHT BE SORE FROM THIS EXERCISE THE FOLLOWING DAY. THE NIGHT OF THE UPHILL RUN AND THROUGHOUT THE DURATION OF MY INJURY THE PAIN SUBSIDED AT A VERY SLOW RATE.

18. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g., the machine employee struck against or which struck him, the vapor or poison inhaled or swallowed, the chemical that irritated his skin, in cases of strains, the thing he was lifting, pulling, etc.): HARD RUNNING SURFACE

19. NATURE OF INJURY OR ILLNESS AND PART OF BODY AFFECTED: PAIN IN LENGTH OF TIBIA DUE TO RUNNING

20. NAME AND ADDRESS OF PHYSICIAN: DR. C. PUCKETT

21. IF HOSPITALIZED, NAME OF HOSPITAL: — [ ] BED PATIENT [ ] EMERGENCY ONLY

22. DATE OF INJURY OR ILLNESS: 11 / 29 / 79 (Month, Day, Year)

23. TIME OF DAY: 3:00 p.m.

24. WERE YOU UNABLE TO WORK ON ANY DAY AFTER DAY OF INJURY? [X] Yes, date last worked ____ [ ] No

WITNESS NAME: | ADDRESS: | TELEPHONE NO.:

WAS ANOTHER PERSON RESPONSIBLE FOR YOUR INJURY OR ILLNESS? IF SO, GIVE NAME, ADDRESS, TELEPHONE, DRIVERS LICENSE: NONE

COULD YOU OR YOUR SUPERVISOR HAVE DONE ANYTHING TO PREVENT INJURY? IF SO, PLEASE EXPLAIN: NO

DATE INJURY REPORTED TO SUPERVISOR: 11-29-79

ARE YOU ENGAGED IN ANY TYPE OF WORK, EMPLOYMENT OR ENTERPRISE OTHER THAN YOUR JOB WITH THE CITY? YES [ ] NO [X]

IF "YES", ON A SEPARATE SHEET STATE NAME AND ADDRESS OF EMPLOYERS, TYPE OF WORK, POSITION AND DATE LAST WORKED.

- EMPLOYEES STATEMENT: THE FACTS AS I HAVE STATED THEM ABOVE ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.
- I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION REGARDING THIS INJURY OR ILLNESS TO REPRESENTATIVES OF THE CITY.

EMPLOYEE'S SIGNATURE: Larry S. Avrech — DATE: 12-6-79

SUPERVISOR

25. HAS EMPLOYEE RETURNED TO WORK? [ ] No, still off work [X] Yes, date returned 11-30-79

26. DID EMPLOYEE DIE? [X] No [ ] Yes, date ____

I HAVE THOROUGHLY INVESTIGATED THE ABOVE INCIDENT. YES [X] NO [ ]

THE INFORMATION AS GIVEN IS COMPLETE AND CORRECT. YES [X] NO [ ]

IMMEDIATE SUPERVISOR: YOU MUST FILL OUT AND ACCOMPANY THIS REPORT WITH THE "SUPERVISORS ACCIDENT INVESTIGATION REPORT" (FORM ES-1531B).

SIGNATURE OF IMMEDIATE SUPERVISOR	TITLE	TELEPHONE	DATE
Richard W. [illegible] III	SERGEANT	271-8133	12-21-79

PLEASE DO NOT USE THIS CO[LUMN]: CASE N[O.] · EMPLOYEE [NO.] 3 · INDUSTR[Y] · SEX · AGE · OCCUPAT[ION] · WEEKLY W[AGE] · COUNT[Y] · ACCIDENT · AGENC[Y] · AGENCY P[ART] · SUPPLEMENT[ARY] AGENC[Y] · NATURE OF · PART OF B[ODY] · INJURY · EXTENT OF · INSURA[NCE] CARRI[ER] 70 · REPORT · CODED · LOST TIME · MEDICAL · INFORMATION · SUBROGATION · RESERVE

ES-1531A (REV. 6-74) STATE FORM 5020

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

CITY OF SAN DIEGO
POLICE DEPARTMENT
EMPLOYEE INJURY INVESTIGATION REPORT

WHITE - SAFETY AND LOSS PREVENTION
GOLD - COMPUTER
PINK - INSURANCE OFFICE
CANARY - ORIGINATING DEPT.

TO BE COMPLETED BY THE INJURED EMPLOYEE

1. FILE NO. C
2. DATE OF INJURY: 11/29/79 (MO. DAY YEAR)
3. TIME OF DAY: 3 ☐ AM ☒ PM
4. HOURS INTO SHIFT WHEN INJURY OCCURRED: 1 HOURS MINS.
5. WERE YOU WORKING OVERTIME AT THE TIME OF INJURY? NO ☒ A EXTENDED SHIFT ☐ B CALL BACK ☐ C

6. NAME OF INJURED: AVRECH LARRY S (LAST NAME, INITIALS)
33. CLASSIFICATION: POLICE OFFICER RECRUIT
7. YEARS IN CLASSIFICATION: LESS THAN 30 DAYS ☐ A; 1 MO. TO 3 MOS. ☒ B; 4 MOS. TO 1 YR. ☐ C; 1 YEAR TO 5 YEARS ☐ D; OVER 5 YEARS ☐ E
8. YEARS WITH CITY: LESS THAN 1 YEAR ☒ F; 1 YEAR TO 5 YEARS ☐ G; 6 YEARS TO 10 YEARS ☐ H; OVER 10 YEARS ☐ I

9. HAVE YOU SUFFERED A PREVIOUS INJURY IN THE PAST YEAR? YES ☐ A NO ☒ B
10. SEX: MALE ☒ A FEMALE ☐ B
11. EMPLOYEE STATUS: SWORN ☐ A HOURLY ☐ B PERM.PART-TIME ☐ C PERM.FULL-TIME ☒ D SEASONAL ☐ E LIMITED ☐ F

34. DEPT. SECTION (E.G., VICE, PATROL, RECORDS, ETC.): POLICE ACADEMY
12. IF A CRIMINAL PROCEDURE, WAS IT? MISDEMEANOR ☐ A FELONY ☐ B
13. NUMBER OF OFFICERS IN CAR: ONE ☐ C TWO ☐ D

14. DIVISION: WESTERN ☐ A EASTERN ☐ B SOUTHEASTERN ☐ C SOUTHERN ☐ D NORTHERN ☐ E
15. PATROL SHIFT: 1 ☐ F 2 ☐ G 3 ☐ H
16. WHAT WAS ACTIVITY OF INJURED: PURSUIT ☐ I APPREHENSION ☐ J BOOKING ☐ K TRAINING ☒ L AMBULANCE ☐ M ADMIN/CLERICAL ☐ N INVESTIGATING ☐ O FAMILY DISTURBANCE ☐ P PATROLLING ☐ Q OTHER ☐ R
17. ENVIRONMENT (CHECK AS MANY AS APPLY): RAIN ☐ A DARK ☐ B FOG ☐ C HEAT ☐ D WINDY ☐ E DUSTY ☐ F CLUTTERED ☐ G CRAMPED ☐ H OTHER ☐ I NOT A FACTOR ☒ J

18. WAS A CITY VEHICLE INVOLVED? YES ☐ A NO ☒ B
IF YES, GIVE EQUIPT. NO.
35. IF YES, GIVE VEHICLE TYPE

19. WAS THE INJURY A BACK STRAIN? YES ☐ A NO ☒ B IF "NO", SKIP TO ITEM NO. 26
20. HAVE YOU SUFFERED A PRIOR BACK INJURY? YES ☐ C NO ☐ D
21. WERE YOU (THIS OCCURRENCE)? LIFTING ☐ E CARRYING ☐ F STRETCHING ☐ G OTHER ☐ H

22. IF AN OBJECT WAS LIFTED OR CARRIED, HOW HEAVY WAS IT? 0-10 LB. ☐ I 11-30 LB. ☐ J 31-50 LB. ☐ K 51-80 LB. ☐ L OVER 80 LB. ☐ M
23. IF LIFTING, WAS IT FROM? GROUND TO WAIST ☐ N WAIST TO SHOULDERS ☐ O ABOVE SHOULDERS ☐ P
24. IF CARRYING, HOW FAR? 0-5 FT. ☐ Q 6-25 FT. ☐ R OVER 25 FT. ☐ S
25. OTHER FACTORS RELATED TO CARRYING/LIFTING (CHECK AS MANY AS APPLY): PERFORMED WITH OTHER PERSON ☐ OBJECT WAS TOO HEAVY ☐ SIZE OR SHAPE OF OBJECT WAS AWKWARD OR BULKY ☐

26. WAS THE INJURY A RESULT OF A "SLIP" OR "FALL"? YES ☐ A NO ☒ B IF "YES", ANSWER ITEMS 27 TO 37
27. WAS YOUR VISION BLOCKED? YES ☐ C NO ☐ D
28. DID THE INJURY OCCUR AT OR NEAR A DOORWAY? YES ☐ E NO ☐ F
29. WHAT WAS THE FLOOR SURFACE TYPE? FLOOR ☐ LADDER ☐ G STAIRS ☐ H VEHICLE STEP ☐ I GROUND ☒ J RAMP ☐ OTHER ☐

36. WHAT WAS THE FLOOR SURFACE MATERIAL? ASPHALT
30. DID "SLIP" OR "FALL" OCCUR AT A LOCATION WHERE THE FLOOR SURFACE TYPE OR MATERIAL CHANGED? YES ☐ N NO ☐ O
37. WHAT WAS THE FLOOR SURFACE CONDITION (E.G., WET, UNEVEN, OILY, ETC.)?

TO BE COMPLETED BY THE IMMEDIATE SUPERVISOR

INTERVIEW THE INJURED EMPLOYEE AND GIVE THE CHAIN OF EVENTS WHICH LED UP TO THE INJURY. INCLUDE A DESCRIPTION OF THE ACTIVITY PERFORMED, THE TASK INVOLVED, TOOLS OR OBJECTS HELD, THE BODY POSITION (E.G., WALKING, STANDING, REACHING, ETC AND THE TYPE OF INJURY AND THE PART OF BODY AFFECTED (38-43).

AVRECH WAS PARTICIPATING IN A PHYSICAL FITNESS TRAINING SESSION WHEN HE INJURED HIS LOWER LEGS RUNNING THE 440 YD DASH

IF THE INJURY OCCURRED WITHIN 60 DAYS OF THE EMPLOYEE STARTING A NEW JOB/PROCESS, BRIEFLY DESCRIBE THE TRAINING YOU PROVIDED.
PROPER RUNNING TECHNIQUES WERE EXPLAINED ALONG WITH WARM-UP AND WARM-DOWN EXERCISES

31. HAVE YOU INSPECTED YOUR WORKAREA/TOOLS? WITHIN THE LAST WEEK ☒ A 1 TO 2 WEEKS AGO ☐ B MORE THAN 2 WEEKS AGO ☐ C
32. HAVE YOU HELD A SAFETY MEETING WITH YOUR CREW? WITHIN THE LAST WEEK ☒ D 1 TO 2 WEEKS AGO ☐ E MORE THAN 2 WEEKS AGO ☐ F
WHAT WAS THE SUBJECT OF THE LAST SAFETY MEETING? PROPER RUNNING TECHNIQUES
DATE INJURY WAS REPORTED TO SUPERVISOR MO. 11 DAY 29 YEAR 7[illegible]

STATE WHAT YOU HAVE DONE TO PREVENT RECURRENCE OF THIS TYPE OF ACCIDENT
Explained proper RUNNING TECHNIQUES AND Recommended A DIET TO HELP REDUCE STRESS TO THE LOWER LEGS

SIGNATURE OF IMMEDIATE SUPERVISOR: Richard W Bennett, Sgt DATE 12-21-79
SIGNATURE OF SUPERINTENDENT DATE

I HAVE INVESTIGATED THE INJURY AS REQUIRED BY AR 75.30. TO THE BEST OF MY KNOWLEDGE, THE FACTS ABOVE ARE COMPLETE AND TRUE AS STATED AND I HAVE DISCUSSED THE INCIDENT WITH THE EMPLOYEE.

I HAVE REVIEWED THE INJURY REPORTS SUBMITTED AS IS REQUIRED BY AR 75.30 AND WILL TAKE ACTION AS APPROPRIATE

SAFETY

33.	34.	35.	36.	37.	38.	39.	40.	41.	42.	43.	44. AGE	45. HEIGHT	46. WEIGHT	47. COMP. RES. / 48. MED. RES.	SAFETY

49. RATE
50. INJURY STATUS: MED. TREAT ☐ A LOST TIME ☐ B FATAL ☐ C OTHER ☐ D
51. WAS INJURY PREVENTABLE? YES ☐ E NO ☐ F
52. COUNTERMEASURE TYPE RECOMMENDED
52.

RM-1564 (9-78)

MITCHELL BUSINESS FORMS
SAN DIEGO (714) 231-3801

.ESS FIRMLY-YOU ARE MAKING FIVE COPI.

THE CITY OF SAN DIEGO

REQUEST FOR LEAVE OF ABSENCE FOR OCCUPATIONAL INJURY OR ILLNESS

INSTRUCTIONS:
EMPLOYEE MUST ORIGINATE OWN REQUEST IN ACCORDANCE WITH PERSONNEL MANUAL SECT. 37.68 (INJURY LEAVE) OR SECT. 37.67 (INDUSTRIAL LEAVE).

FORWARD WHITE, GREEN AND CANARY COPIES TO WORKERS COMPENSATION ADMINISTRATION. PINK COPY RETAINED BY ORIGINATING DEPT. GOLDENROD COPY RETAINED BY EMPLOYEE.

EMPLOYEE REQUEST

PRINT NAME (LAST) (FIRST) (INITIAL): AVRECH LARRY S

JOB CLASSIFICATION: POLICE RECRUIT

SOCIAL SECURITY NUMBER: 360-46-2298

DEPARTMENT/DIVISION: SAN DIEGO POLICE DEPARTMENT

DATE INJURED: 11-29-79

CONTINUING DISABILITY: YES ☒ NO ☐

RECURRENCE OF AN OLD DISABILITY: YES ☐ NO ☒

BRIEF DESCRIPTION OF OCCUPATIONAL INJURY OR ILLNESS: PAIN IN LENGTH OF TIBIA (BOTH LEGS) DUE TO RUNNING (POSS. SHIN SPLINTS)

I REQUEST THE FOLLOWING LEAVE FOR MY DISABILITY.

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION REQUESTED BY MY EMPLOYER.

x Larry S. Avrech #2900 — SIGNATURE

12-6-79 — DATE

PAYROLL SYMBOLS		
V		VACATION WITH PAY
S		SICK LEAVE WITH PAY
I		INJURY LEAVE WITH PAY*
W		INDUSTRIAL LEAVE WITH PAY*
C		WORKER'S COMPENSATION ONLY**
A		LEAVE WITHOUT PAY**

* IF YOUR INDUSTRIAL OR INJURY LEAVE IS DENIED YOU WILL BE NOTIFIED AND THIS REQUEST WILL BE CHANGED TO SICK LEAVE WITH PAY (IF SICK LEAVE CREDITS ARE ACCRUED).

** EMPLOYEES ON WORKERS' COMPENSATION BENEFITS ONLY OR LEAVE WITHOUT PAY ARE REQUIRED TO PREPAY GROUP INSURANCE PREMIUMS TO AVOID CANCELLATION OF EMPLOYEE & DEPENDENT COVERAGE. CALL INSURANCE CLERK AT 236-5691 IMMEDIATELY TO ARRANGE FOR PREMIUM PAYMENTS.

PHYSICIAN'S EVALUATION

TREATING PHYSICIAN | ADDRESS | TELEPHONE

BRIEF DIAGNOSIS

BRIEF PROGNOSIS FOR RECOVERY

WAS DISABILITY CAUSED BY YOUR PATIENT'S CITY EMPLOYMENT ACTIVITIES? YES ☐ NO ☐

DATE OF FIRST TREATMENT | DATE FIRST UNABLE TO WORK | DATE ABLE TO RETURN TO FULL DUTY: | DATE DISCHARGED FROM TREATMENT

CAN YOUR PATIENT RETURN TO WORK IN A TEMPORARY LIGHT DUTY CAPACITY? YES ☐ NO ☐

IF YES, PLEASE ADVISE OF APPROXIMATE DURATION, PHYSICAL RESTRICTIONS AND/OR OTHER GUIDANCE AND DATE ABLE TO RETURN TO LIGHT DUTY: ____________

WILL YOUR PATIENT EVENTUALLY BE ABLE TO RESUME HIS OR HER REGULAR CITY OCCUPATION? YES ☐ NO ☐

IF NO, WHAT PERMANENT DISABILITY DO YOU ANTICIPATE?

PHYSICIAN'S SIGNATURE | DEGREE | DATE

DEPT/DIVISION

INCLUSIVE DATES OF ABSENCE
FIRST DATE ____________ LAST DATE ____________

TOTAL WORK HOURS ABSENT ____________

HAS EMPLOYEE BEEN ASSIGNED TO LIGHT DUTY? YES ☐ NO ☐

RECOMMEND ☐ APPROVAL ☐ DISAPPROVAL

HOURLY RATE $ ____________

NO. HOURS OF ACCRUED SICK LEAVE PRIOR TO THIS DISABILITY PERIOD. ________

IF INJURY OR INDUSTRIAL LEAVE IS DISAPPROVED, WHAT TYPE OF LEAVE IS RECOMMENDED?

DEPT/DIVISION HEAD | DATE

OMP. APPROVED

COMMENT/INSTRUCTIONS

PRESS F LY-YOU ARE MAKING FIVE COPIES

THE CITY OF SAN DIEGO

REQUEST FOR LEAVE OF ABSENCE FOR OCCUPATIONAL INJURY OR ILLNESS

INSTRUCTIONS:
EMPLOYEE MUST ORIGINATE OWN REQUEST IN ACCORDANCE WITH PERSONNEL MANUAL SECT. I-4 (INJURY LEAVE) OR SECT. I-5 (INDUSTRIAL LEAVE).

FORWARD WHITE, GREEN AND CANARY COPIES TO WORKERS COMPENSATION ADMINISTRATION. PINK COPY RETAINED BY ORIGINATING DEPT. GOLDENROD COPY RETAINED BY EMPLOYEE.

EMPLOYEE REQUEST

PRINT NAME (LAST) (FIRST) (INITIAL): AVRECH LARRY S

JOB CLASSIFICATION: POLICE RECRUIT OFFICER

SOCIAL SECURITY NUMBER: 360-46-2298

DEPARTMENT/DIVISION: SAN DIEGO POLICE DEPARTMENT

DATE INJURED: NOV 27th 1979

CONTINUING DISABILITY: YES ☐ NO ☒

RECURRENCE OF AN OLD DISABILITY: YES ☐ NO ☒

BRIEF DESCRIPTION OF OCCUPATIONAL INJURY OR ILLNESS: SHIN SPLINTS

I REQUEST THE FOLLOWING LEAVE FOR MY DISABILITY.

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION REQUESTED BY MY EMPLOYER.

x Larry S Avreck #2900 — SIGNATURE

12-21-79 — DATE

PAYROLL SYMBOLS		
V		VACATION WITH PAY
S		SICK LEAVE WITH PAY
I		INJURY LEAVE WITH PAY*
D		INDUSTRIAL LEAVE WITH PAY*
C		WORKER'S COMPENSATION ONLY**
A		LEAVE WITHOUT PAY**

* IF YOUR INDUSTRIAL OR INJURY LEAVE IS DENIED YOU WILL BE NOTIFIED AND THIS REQUEST WILL BE CHANGED TO SICK LEAVE WITH PAY (IF SICK LEAVE CREDITS ARE ACCRUED).

** EMPLOYEES ON WORKERS' COMPENSATION BENEFITS ONLY OR LEAVE WITHOUT PAY ARE REQUIRED TO PREPAY GROUP INSURANCE PREMIUMS TO AVOID CANCELLATION OF EMPLOYEE & DEPENDENT COVERAGE. CALL INSURANCE CLERK AT 236-6690 IMMEDIATELY TO ARRANGE FOR PREMIUM PAYMENTS.

PHYSICIAN'S EVALUATION

TREATING PHYSICIAN: C Puckett

ADDRESS: 111 Elm Street, San Diego 92101

TELEPHONE: 239-9201

BRIEF DIAGNOSIS: Resolving Shin splint

BRIEF PROGNOSIS FOR RECOVERY: Good

WAS DISABILITY CAUSED BY YOUR PATIENT'S CITY EMPLOYMENT ACTIVITIES? YES ☐ NO ☐

DATE OF FIRST TREATMENT: 12-7-79

DATE FIRST UNABLE TO WORK: 12-7-79

DATE ABLE TO RETURN TO FULL DUTY: 12-22-79

DATE DISCHARGED FROM TREATMENT: ——

CAN YOUR PATIENT RETURN TO WORK IN A TEMPORARY LIGHT DUTY CAPACITY? YES ☐ NO ☒

IF YES, PLEASE ADVISE OF APPROXIMATE DURATION, PHYSICAL RESTRICTIONS AND/OR OTHER GUIDANCE AND DATE ABLE TO RETURN TO LIGHT DUTY: ______

Full duty 12-22-79

WILL YOUR PATIENT EVENTUALLY BE ABLE TO RESUME HIS OR HER REGULAR CITY OCCUPATION? YES ☑ NO ☐

IF NO, WHAT PERMANENT DISABILITY DO YOU ANTICIPATE?

C Puckett — PHYSICIAN'S SIGNATURE

MD — DEGREE

12-21-79 — DATE

DEPT/DIVISION

INCLUSIVE DATES OF ABSENCE

FIRST DATE ______ LAST DATE ______

TOTAL WORK HOURS ABSENT ______

HAS EMPLOYEE BEEN ASSIGNED TO LIGHT DUTY? YES ☐ NO ☐

RECOMMEND ☐ APPROVAL ☐ DISAPPROVAL

HOURLY RATE $ ______

NO. HOURS OF ACCRUED SICK LEAVE PRIOR TO THIS DISABILITY PERIOD. ______

IF INJURY OR INDUSTRIAL LEAVE IS DISAPPROVED, WHAT TYPE OF LEAVE IS RECOMMENDED?

DEPT/DIVISION HEAD ______ DATE ______

WORK. COMP.

APPROVED

DISAPPROVED

PER ______

DATE ______

COMMENT/INSTRUCTIONS

CS-14-25B (REV. 9-78)

PRESS LY-YOU ARE MAKING FIVE COPIES

THE CITY OF SAN DIEGO

REQUEST FOR LEAVE OF ABSENCE FOR OCCUPATIONAL INJURY OR ILLNESS

INSTRUCTIONS:
EMPLOYEE MUST ORIGINATE OWN REQUEST IN ACCORDANCE WITH PERSONNEL MANUAL SECT. I-4 (INJURY LEAVE) OR SECT. I-5 (INDUSTRIAL LEAVE).

FORWARD WHITE, GREEN AND CANARY COPIES TO WORKERS COMPENSATION ADMINISTRATION. PINK COPY RETAINED BY ORIGINATING DEPT. GOLDENROD COPY RETAINED BY EMPLOYEE.

EMPLOYEE REQUEST

PRINT NAME (LAST) (FIRST) (INITIAL): AVRECH LARRY S

JOB CLASSIFICATION: POLICE RECRUIT

SOCIAL SECURITY NUMBER: 360-46-2298

DEPARTMENT/DIVISION: SAN DIEGO POLICE DEPARTMENT

DATE INJURED: 11-27-79

CONTINUING DISABILITY: YES ☒ NO ☐

RECURRENCE OF AN OLD DISABILITY: YES ☐ NO ☒

BRIEF DESCRIPTION OF OCCUPATIONAL INJURY OR ILLNESS: SHIN SPLINTS BOTH LEGS

I REQUEST THE FOLLOWING LEAVE FOR MY DISABILITY.

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION REQUESTED BY MY EMPLOYER.

x Larry S. Avrech
SIGNATURE

1-4-80
DATE

PAYROLL SYMBOLS		
V		VACATION WITH PAY
S		SICK LEAVE WITH PAY
I		INJURY LEAVE WITH PAY*
D		INDUSTRIAL LEAVE WITH PAY*
C		WORKER'S COMPENSATION ONLY**
A		LEAVE WITHOUT PAY**

* IF YOUR INDUSTRIAL OR INJURY LEAVE IS DENIED YOU WILL BE NOTIFIED AND THIS REQUEST WILL BE CHANGED TO SICK LEAVE WITH PAY (IF SICK LEAVE CREDITS ARE ACCRUED).

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PHYSICIAN'S EVALUATION

TREATING PHYSICIAN: C. Puckett M.D.

ADDRESS: 111 Elm St S.D.

TELEPHONE: 239-9201

BRIEF DIAGNOSIS: Resolved Shin Splints.

BRIEF PROGNOSIS FOR RECOVERY: Good

WAS DISABILITY CAUSED BY YOUR PATIENT'S CITY EMPLOYMENT ACTIVITIES? YES ☒ NO ☐

DATE OF FIRST TREATMENT: 12-07-79

DATE FIRST UNABLE TO WORK: 12-07-79

DATE ABLE TO RETURN TO FULL DUTY: 12-22-79

DATE DISCHARGED FROM TREATMENT: 1/4/80

CAN YOUR PATIENT RETURN TO WORK IN A TEMPORARY LIGHT DUTY CAPACITY? YES ☐ NO ☐

IF YES, PLEASE ADVISE OF APPROXIMATE DURATION, PHYSICAL RESTRICTIONS AND/OR OTHER GUIDANCE AND DATE ABLE TO RETURN TO LIGHT DUTY: ____

WILL YOUR PATIENT EVENTUALLY BE ABLE TO RESUME HIS OR HER REGULAR CITY OCCUPATION? YES ☒ NO ☐

IF NO, WHAT PERMANENT DISABILITY DO YOU ANTICIPATE?

RELEASED FROM CARE
NO PERMANENT DISABILITY

C Puckett
PHYSICIAN'S SIGNATURE

MD
DEGREE

1/4/80
DATE

DEPT/DIVISION

INCLUSIVE DATES OF ABSENCE

FIRST DATE ____ LAST DATE ____

TOTAL WORK HOURS ABSENT ____

HAS EMPLOYEE BEEN ASSIGNED TO LIGHT DUTY? YES ☐ NO ☐

RECOMMEND ☐ APPROVAL ☐ DISAPPROVAL

HOURLY RATE $ ____

NO. HOURS OF ACCRUED SICK LEAVE PRIOR TO THIS DISABILITY PERIOD. ____

IF INJURY OR INDUSTRIAL LEAVE IS DISAPPROVED, WHAT TYPE OF LEAVE IS RECOMMENDED?

DEPT/DIVISION HEAD ____ DATE ____

WORK. COMP.

APPROVED

DISAPPROVED

PER ____

DATE ____

COMMENT/INSTRUCTIONS

CS-14-258 (REV. 9-78)