

**APPEAL TO CIVIL SERVICE COMMISSION
Regulation 32 (Injury and Disability)**

Date _____

I. Name _____ Payroll Number _____
Address _____ Phone Number _____
(include ZIP Code) _____ E-mail _____
Position _____ Department _____

II. Name of Attorney _____ Law Firm _____
Address _____ Phone Number _____
(include ZIP Code) _____ E-mail _____

III. APPEAL FROM: CHECK TYPE OF APPEAL AND COMPLETE RELATED INFORMATION

A. **Regulation 32.11** (refusal to return to work - active or limited duty)
Ordered to: Active Duty Limited Duty Date ordered to duty _____

NOTE: Please attach a copy of the Encounter Form showing the order to active/limited duty.

B. **Regulation 32.12** (existence, nature, or service-connection of disability)
Date of Department's written determination _____ Date of receipt by employee _____

NOTE: Please attach a copy of Department's written determination denying existence/service-connection of disability.

C. **Regulation 32.047, 32.054 or 32.0614** (refusal to accept City treatment)
Date employee refused authorized treatment _____
Type of treatment refused (describe briefly) _____

IV. TYPE OF DISABILITY: (check one) Temporary Permanent/Partial Permanent/Total

V. DATES: YOU MUST COMPLETE THIS SECTION

Date of injury _____ Date of recurrence (if applicable) _____

ALL dates for which you are claiming Injured-on-Duty (IOD) benefits:

Do **not** include dates for which IOD has been received. _____

If presently out of work, state if claim is ongoing. _____

NOTE: Commission may only accept appeals claiming more than ten (10) days of IOD benefits

VI. STATE CONCISELY THE ISSUES TO BE RAISED AT YOUR HEARING: (attach additional sheets, if needed)

(Appellant's signature)

(date)

(Attorney's signature)

(date)