LAFD Catastrophic Illness/Injury Leave Donation Program

APPLICATION FOR BENEFITS

Applicant Information

Name: _____ Employee ID: _____
Last *First* *M.I.*

Address: _____
Number, Street, City, State, Zip Code

Home Phone: _____ Total Number of Days of Leave Requested: _____

Work Phone: _____ Approximate Dates of Leave Requested: ___/___/___ **to** ___/___/___
(month/day/year)

Cell Phone: _____

Request

Please provide a brief explanation for your request for assistance:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____