Workers' Compensation Leave Election Form

WC Leave Election Form

Employee: _____ Date of Injury: _____

Job Title: _____ Department: _____

Supervisor: _____ SS#: _____

Dates Out of Work: _____

AmeriSys Physician Selected: _____

☐ I am an hourly employee or an employee scheduled to work less than 20 hours per week and therefore do not accrue leave.

On the date noted above, I was injured, became ill, or was exposed to an occupational disease while on the job with the Georgia Vocational Rehabilitation Agency. I have been advised that if I have to lose any time from work because of the above, I will need to choose how I will be paid. I have selected the following payment option [CHOOSE ONLY ONE]:

☐ I have selected to use some or all of my accrued FLSA compensatory time and/or accrued sick, annual, or personal leave while absent due to the above. I understand that if I use all of my accrued time and leave, I will receive workers' compensation payments if I am still unable to work. I have been advised that I cannot receive workers' compensation payments and regular salary (i.e., use of accrued time or leave) at the same time.

☐ I have selected to receive workers' compensation payments for lost salary instead of using accrued FLSA compensatory time or accrued leave to be paid in regular bi-weekly installments. I understand that I will be placed in leave without pay status while receiving workers' compensation payments. I also understand that the first seven (7) days of my leave without pay absence will not be paid by workers' compensation unless I am out of work due to my injury/illness/exposure for no less than twenty-eight (28) days.

☐ I have selected to use some or all of my accumulated FLSA compensatory time and/or sick, annual or personal leave through (enter date: _____) at which time I wish to be paid workers' compensation benefits for loss of wages.

* I understand that all absences from work due to workers' compensation claims that qualify, as a serious health condition, will be charged to available Family and Medical Leave.

* I am aware that I may make changes regarding payment of selection options by submitting my request in writing to the Human Resources Department workers' compensation liaison with a copy to my supervisor.

Signature of Employee: _____ Date: _____

Copies of this form are to be forwarded to the GVRA *Human Resources Department worker's' compensation liaison.* 4/2015