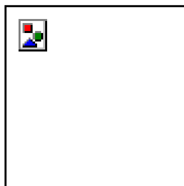

Workers' Compensation
Leave Election Form

Date: ______________________________

To: DOAS/Risk Management Services
200 Piedmont Ave SE, Suite 1220 West
Atlanta, GA 30334
Fax 404-657-1188

From:_____________________________ Name of Injured employee)

Date of Injury: _______________________

Contact Number ______________________

Re: Workers' Compensation (WC) Benefit Payments

On the above referenced injury date, I was injured while working for______________________(agency name). If I lose any time from work because of this injury, I request that I be paid in the manner shown below. (Please initial beside the option you choose)

_______From my accumulated sick leave and if necessary, from accumulated annual leave before receiving WC benefits for loss of wages. I understand that when I have used my accumulated sick and annual leave, I will receive WC benefits if I am still unable to work due to the injury.

_______WC Benefits for loss of wages instead of full pay from accumulated sick and annual leave to be paid in regular weekly installments, effective_______________(date).

_______From my accumulated sick leave and if necessary from my accumulated annual leave through ____________(date) after which time I wish to be paid WC benefits for loss of wages.

Signature of Injured Employee____________________________________Date ____________

If a mark is used, two witnesses are required:

_______________________________________ _______________________________________
Witness Date Witness Date