LEAVE ELECTION FORM

DATE: ____________________________________

TO: DOAS/Division of Risk Management Services
Worker's Compensation Unit
P.O. Box 38198, Capitol Hill Station
Atlanta, GA 30334

FROM: ____________________________________
(Injured Employee's Name-Please Print)

____
(Date of Injury)

____
(Contact Number)

RE: Workers' Compensation Payments

If the Injury which occurred is a work-related injury, the Georgia Workers' Compensation Law states that you may be entitled to compensation equivalent to 66 2/3% of your average weekly earnings up to a maximum of $500.00 per week for time lost from work due to that injury, if your absence from work is recommended by an authorized physician.

The first seven days of disability (including the day of injury) are not compensable unless you are unable to work for 21 consecutive days or more. If you are unable to work for 21 days or more, you may be compensated, at that time, for the first seven days of disability, if you have not used accrued leave.

Even if you have not incurred lost time from work, it is requested that you make a selection of one of the options of payment below should you lose time due to this reported injury. If you fail to complete and return this form, lost time will automatically be counted as sick and annual leave. After your leave has been exhausted, you will then begin to receive Workers' Compensation if you are deemed eligible.

On ________________ (Date of Injury), I was injured on the job while working for the _________________ (Agency Name). If I have to lose any time because of this injury, I request that I be paid as follows:

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

☐ Workers' Compensation benefits for loss of wages instead of full pay from accumulated sick and annual leave to be paid in regular bi-weekly installments. Effective: _______________(Date).

☐ From my accumulated sick leave, and if necessary, from my accumulated annual leave through _______________ (Date) at which time I wish to be paid Workers' Compensation benefits for lost wages.

____
Signature of Injured Employee

____
Date

IF A MARK IS USED, TWO WITNESSESS ARE REQUIRED:

(1) ____

(2) ____