NOTICE OF INJURY AND LEAVE ELECTION FORM

This form is NOT to be used for disability due to certain injuries (Special Injury Pay)

Employees are not eligible to receive Workers' Compensation Wage benefits until after 7 days of lost work time.

On ______________(date), I was injured, became ill, or was exposed to an occupational disease while on the job with the Georgia Department of Corrections.

If I have to lose any time because of the injury, I request that I be paid (check one of the following):

( ) From my accumulated compensatory time, sick, annual and/or personal leave before receiving Workers' Compensation benefits for loss of wages. I understand that when all of my accumulated time and leave has been exhausted, I will receive Workers' Compensation benefits if I am still unable to work.

( ) From my accumulated compensatory time, sick, annual and/or personal leave through ___________________, at which time I wish to be paid Workers' Compensation benefits for lost wages.

( ) Workers' Compensation benefits for loss of wages instead of full pay from accumulated comp time and leave, to be paid in regular bi-weekly installments. I understand I will be placed in a leave without pay status while receiving Workers' Comp wage payments and I am responsible for ensuring direct payments of any benefits.

I understand that all absences from work due to Workers' Compensation claims that qualify as a serious health condition should be charged to available Family Leave.

Print Employee Name:__________________________________ Employee I.D.#_______________

Employee Signature: __________________________________ Date:________________________

If employee is unable to sign, a representative may sign on the employee's behalf.

____ ______________________________

Signature of Representative | Relationship to Employee

____ ______________________________

HR Representative Signature | Date Received

Record Retention: Upon completion, this form shall be retained permanently in the employee's official and local HR files.