**LEAVE ELECTION FORM**

DATE:

TO: DOAS/Division of Risk Management Services

Workers' 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

 On (**Date of Injury**), I was injured on the job while working for the

**Valdosta State University** (**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)

Forward form to VSU Human Resources and Employee Development Department. Revised: 11/14/03