

# 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

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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) \_\_\_\_\_

Forward form to VSU Human Resources and Employee Development Department.