Georgia State University

Insurance & Risk Management

# LEAVE ELECTION FORM
# FOR AN ON-THE-JOB INJURY/ILLNESS

Date: _____

To: Department of Administrative Services, Workers' Compensation Unit

Co: Benefits Office of Human Resources, Georgia State University

From: Georgia State University, Department of Insurance and Risk Management

Re: Selection of Workers' Compensation Pay Options for Injured Employee

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On the date of _____, I, _____, was injured on the job while working for the Department of _____ at Georgia State University. If I lose any time because of this injury, I request that I be paid in the following manner:

☐ From my accumulated sick leave and ☐ from my accumulated vacation leave before receiving Workers' Compensation benefits for loss of wages.

☐ Workers' Compensation benefits from the State of Georgia for loss of wages instead of full pay from accumulated sick and vacation leave from my employer, Georgia State University.
**Note: *If this selection is made, employee must initial all statements below.***
_____I understand that I will be compensated at no more than 66 2/3% of my weekly wage (max of $675/week).
_____I understand that I will not be paid for the first 7 calendar days that I am out of work unless I am out of work due to my injury/illness for 21 consecutive days.
_____ I understand that I will need to contact Georgia State University, Human Resources Benefits, and make arrangements to keep my employee benefits current while I am out of work.

☐ From my accumulated sick leave and, if necessary, from my accumulated vacation leave from the date of _____ until the date of _____ after which time I wish to be paid Workers' Compensation benefits instead of full, regular pay.

_____ I understand that I may change my Leave Election at any time by filling out another Form and submitting the original to the Georgia State University Department of Insuracnce and Risk Management.

**Note: Employee must initial above statement before signing**

_____ _____
Signature of Employee (as shown on payroll) Date Signed

**GSU Human Resources to complete this section**

The GSU Employee, _____, SSN: _____,
has a balance of _____ vacation hours and _____ sick leave hours.

Leave will end as of _____

Weekly Wage Rate$_____

Short Term Disability Enrollment _____

Verified by: _____ Date _____
(Name of Human Resources Employee)

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