# Workers' Compensation
# Leave Election Form

Date: _____

To: DOAS/Risk Management Services
200 Piedmont Ave SE, Suite 1220 West
Atlanta, GA 30334
Fax 404-657-1188

From:_____ Name of Injured employee)

Date of Injury: _____

Contact Number _____

**Re: Workers' Compensation (WC) Benefit Payments**

On the above referenced injury date, I was injured while working for_____(agency name). If I lose any time from work because of this injury, I request that I be paid in the manner shown below. (Please initial beside the option you choose)

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

_____WC Benefits for loss of wages instead of full pay from accumulated sick and annual leave to be paid in regular weekly installments, effective_____(date).

_____From my accumulated sick leave and if necessary from my accumulated annual leave through _____(date) after which time I wish to be paid WC benefits for loss of wages.

Signature of Injured Employee_____Date _____

If a mark is used, two witnesses are required:

_____ _____
Witness Date Witness Date