

Workers' Compensation Use of Leave Options Form

First Name _____ Last Name _____ Date of Injury _____

If I should lose time from work as a result of an on-the-job injury, this is to certify that the use of leave options available have been fully explained to me. I understand these options are available to me only if the agency determines the claim is compensable and accepts liability. After careful consideration, I elect the option(s) marked below.

Option 1 Elect to take sick or vacation leave (if available) during the required seven-day waiting period and then go on workers' compensation leave and begin receiving workers' compensation weekly benefits.

Option 2 Elect to go on workers' compensation leave immediately with no pay for the seven-day waiting period, and then begin receiving workers' compensation weekly benefits.

Note: In either option above if the injury results in disability for more that 21 days, the workers' compensation weekly benefit shall be allowed from the date of the disability.

Option 3 Elect to supplement the workers' compensation weekly benefit with the use of partial earned sick or vacation leave in accordance with the Supplemental Leave Schedule provided by the Office of State Personnel. Use of the Supplemental leave benefit applies only while receiving temporary total disability compensation.

Note: All elections involving the use of earned sick or vacation leave are subject to their availability at the time of the incident.

I understand that once I elect an option, that the election shall be irrevocable as to each individual incident.

Employee Signature _____ Date _____

Department _____ Employee ID _____

Submit completed form to the Leave Administration Unit

Mailing Address:
Campus Box 7215
Raleigh, NC 27695

Fax Number: (919) 513-2528

Physical Address:
Administrative Services - Bldg II
2711 Sullivan Dr., Suite 200