

Georgia Institute of Technology

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
_____ (Department 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 vacation leave, before receiving Workers' Compensation benefits for loss of wages. I understand that when I have used my accumulated sick and vacation 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 vacation leave to be paid in regular bi-weekly installments. Effective: _____ (Date).
- From my accumulated sick leave, and if necessary, from my accumulated vacation 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) _____

