



Department of Administrative Services

Customer Focused, Performance Driven

Nathan Deal
Governor

Sid Johnson
Commissioner

Leave Election Form

Date: _____

To: DOAS/Risk Management Services
200 Piedmont Ave SE, Suite 1208 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