GEORGIA DEPARTMENT OF HUMAN SERVICES
Human Resources Policy #1702 A1

LEAVE ELECTION FORM

Date: _____

To: DOAS/Risk Management Services
200 Piedmont Ave SE, Suite 1208 West Atlanta, GA 30334
Fax 404-657-1188

Employee Name: _____

Injury Date: _____

Employee Contact Number: _____

Re: Workers' Compensation (WC) Benefit Payments

On the above referenced injury date, I was injured while working for the Department of Human Services. 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 wages.

Employee Signature:	**Date:**
If a mark is used in the above employee signature, two witnesses are required.	
Witness 1 Name:	**Date:**
Witness 2 Name:	**Date:**