



## EMPLOYEE USE OF LEAVE OPTIONS FORM

The following leave options are available during the seven (7) day waiting period to receive temporary total disability (TTD) benefits for an injured employee that loses time from work as a result of an on-the-job injury that is determined by their employing agency to be compensable.

**Check one of the options below to elect leave usage for the seven (7) day waiting period.**

- Option 1:** Elect to take sick or vacation leave during the required seven-day waiting period and then go on workers' compensation leave and begin drawing workers' compensation weekly benefits.
- Option 2:** Elect leave without pay for the seven-day waiting period and then began drawing workers' compensation weekly benefits.

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

**Check one of the options below to elect the option to supplement workers' compensation payments after the seven (7) day waiting period.**

- Option 1:** Elect to supplement the workers' compensation weekly benefit with the use of partial earned sick or vacation leave in accordance with the schedule provided by the Office of State Human Resources. Use of the supplemental leave benefit applies only while drawing temporary total disability compensation.
- Option 2:** Elect workers' compensation payments without supplemental leave usage.

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

By signing below, I certify that in the event of any overpayment of wages or workers' compensation benefits, such amounts shall be deducted from future benefits owed or immediately repaid in cash by the employee. This election may only be changed by completing a new form.

_____ Employee Name (print)	_____ Date of Injury
_____ Employing Agency	_____ Division/Unit
_____ Employee Signature	_____ Date

### Supervisor Completes This Section

The above named employee was injured on \_\_\_\_\_ and was placed on workers' compensation leave  
effective \_\_\_\_\_. I completed an Incident Investigation Report for this injury and submitted it to  
my agency's workers' compensation administrator along with all information necessary to complete the Industrial  
Commission Form 19, Employer's Report of Employee's Injury of Occupational Disease to the Industrial Commission.

_____ Supervisor Name (print)	_____ Title
_____ Supervisor Signature	_____ Date