Election of Leave Benefits with Workers' Compensation

Name _______________________________________Employee Number _______________

Position _______________________________________Department/Campus_______________

This employee is absent from duty because of a job-related illness or injury beginning on _____________(date of first absence attributable to illness or injury). If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

_______________________________________ _______________________ ____________________

District Authorized Signature | Position | Date

Employee Choice:

If I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I also understand the district will continue to pay its contribution toward the cost of my group health insurance coverage (if applicable) as long as I am on **paid** leave and/or family and medical leave (FMLA). I further understand that I will be responsible for paying all health insurance premiums if I am on **unpaid** leave that is not FMLA leave.

If I miss time due to this injury, I choose the following option:

☐ I choose to use only _____________ days of available paid leave at this time.

☐ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness or pre-injury wage.

☐ I choose **not** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from Friendswood Independent School District while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will only receive workers' compensation wage benefits for any absences resulting from my work related illness/injury after the seventh day of lost time, unless and until I communicate to the district a change in my decision.

Employee signature ____ Date ____________________

For Claims Reporting Purposes Only:	
For all employees: Amount of leave paid to employee: $ ________.____ Daily rate: $____________ Period of payment from ____ /____ /____ through ____ /____ /____ for ______days **or**______weeks	For hourly employee only: Hourly rate: $_______._____ Number of hours paid:_______