WAGE AND SICK LEAVE VERIFICATION
FOR WORKERS' COMPENSATION

EMPLOYEE'S NAME: ____

SSN: ___________________________

SCHOOL / DEPARTMENT: ____

DATE OF ACCIDENT: _________________________

DATE DISABILITY BEGAN: _____________________

NUMBER OF DAYS OF ACCRUED SICK LEAVE: ________________________

Please have the employee sign ***one*** *of the following statements. By signing this form, the employee does not give up any rights to his/her claim.*

I, _________________________ CHOOSE TO USE MY ACCRUED LEAVE IN LIEU OF WORKERS' COMPENSATION BENEFITS FOR LOST WAGES
(I will receive my regular paycheck with its usual deductions. Deducted leave will not be reimbursed).

I would like to use _________ days of my sick leave and _______ days of my vacation time.

____
Date Signed by Employee

I, __________________________ CHOOSE TO CLAIM WORKERS' COMPENSATION BENEFITS FOR LOST WAGES IN LIEU OF USING MY SICK LEAVE.
(Compensation at two-thirds of my average weekly wage will commence following more than seven excused days of disability. I will remain responsible for my standard payroll deductions)

____
Date Signed by Employee

Employee's Supervisor: _________________________ _______________________
Signature / Date Printed Name

Payroll Department: ___________________________ _______________________
Signature / Date Printed Name

IF YOU ARE TEMPORARILY DISABLED SEVEN (7) CALENDAR DAYS OR LESS, SC LAW (SECTION 42-9-200) PROHIBITS THE PAYMENT OF WORKERS' COMPENSATION LOST WAGES. INCREMENTAL TIME TAKEN FOR MEDICAL VISITS DOES NOT CONSTITUTE A DISABILITY.