EAST CENTRAL INDEPENDENT SCHOOL DISTRICT

Workers' Compensation Leave Request

Employee Name____

SS#______________________________ Campus___________________________________

Injury Date________________________ ____

Beginning Absence Date__________________________ ______________________________

Approximate Ending Date________________ _____________________________________

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation temporary income benefits until my absence exceeds **seven (7) calendar days.** 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 worker's compensation temporary income benefits until I have exhausted all of my paid leave.

__________ I choose **not** to use any available paid leave at this time. I understand that I will not receive any regular payments from East Central ISD while receiving temporary 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 ill or injury, unless or until I communicate (in writing) to the district payroll office a change in my decision.

Contact the payroll office if you have any questions concerning the impact of temporary income benefits (Workers' Compensation) on your Teacher Retirement System status.

____ ________________________

Employee Signature Date

05/00