

WAGE AND SICK LEAVE VERIFICATION FOR WORKERS' COMPENSATION

Code **EGAA-E** Issued **08/23/02**

EMPLOYEE'S NAME: SSN: - -

SCHOOL/DEPARTMENT:

ACCIDENT: / / DATE DISABILITY BEGAN // /

NUMBER OF DAYS OF ACCRUED SICK LEAVE:
(Risk Management has access to this information)

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

OPTION ONE

I, (print name) choose to use my accrued sick leave in lieu of worker's compensation benefits for lost wages. **Sick leave will no longer be reimbursed.**

Once my sick leave has been depleted, I elect to convert over to worker's compensation benefits.

YES NO N/A

Signature: Date: / /

OPTION TWO

I, (print name) choose to claim worker's compensation benefits for lost wages in lieu of using my sick leave.

Signature: Date: / /

(The employee's supervisor must sign this form.)

Employee Supervisor's Signature:
Print Name: Date: / /

IF YOU ARE OUT OF WORK SEVEN (7) CALENDAR DAYS OR LESS, SOUTH CAROLINA LAW PROHIBITS PAYMENT OF LOST WAGES.

Richland County School District One