Mary Daniels
Willis ISD Human Resources
Leave and Substitute Specialist
612 N Campbell, Willis, TX, 77378
Phone 936.890.3187 Fax 936.856.1338

WILLIS ISD
LEAVE ELECTION FORM-WORK RELATED INJURY

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 Date

Employee choice:
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 that 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. 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 -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 Willis ISD 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 receive only workers' compensation wage benefits for any absences resulting from my work-related illness or injury, unless and until I communicate to the district a change in my decision.

_____/_____/_____
Employee signature Print Name 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 employees only:* Hourly rate: $____.___ Number of hours paid: _____