WAGE AND SICK LEAVE VERIFICATION
FOR WORKERS' COMPENSATION

EMPLOYEE'S NAME: _____Email: _____

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 **SICK LEAVE** IN LIEU OF WORKERS' COMPENSATION BENEFITS FOR LOST WAGES
sick leave will **NOT be reimbursed**

_____
Date Signed by Employee

I, _____ CHOOSE TO CLAIM TEMPORARY DISABLIITY **WORKERS' COMPENSATION** BENEFITS FOR LOST WAGES IN LIEU OF USING MY SICK LEAVE.
Please note that retirement contributions will stop while you are out of work and using WC benefits. This may delay your eligible retirement date.

If you elect to use WC payments, are you interested in direct deposit? YES _____ NO _____
If direct deposit is preferred, we may require your personal email address to initiate the transaction process. Personal email address: _____

_____
Date Signed by Employee

Employee's Supervisor: _____ _____
Signature / Date Printed Name

Payroll Department: _____ _____
Signature / Date Printed Name

IF YOU ARE OUT OF WORK LESS THAN SEVEN (7) CALENDAR DAYS, SC LAW (SECTION 42-9-200) PROHIBITS THE PAYMENT OF WORKERS' COMPENSATION LOST WAGES.