|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EMPLOYEE’S NAME** (Last, First, MI – As on payroll) | | | | | DATE OF ACCIDENT | | | CURRENT SICK LEAVE | | |
| I understand that I have the following options while I am unable to work because of a work-related injury covered by Workers’ Compensation. | | | | | | | | | | |
| 1. I may elect to have my accrued sick leave applied toward my net income. I understand that the combination of workers’ compensation lost time payments and sick leave cannot exceed my net income. | | | | | | | | | | |
| 2. I have the right to file a revised Form A-450 changing my option, however, I understand I am limited to one choice per pay period. | | | | | | | | | | |
| Having read the above, I hereby elect the following: | | | | | | | | | | |
|  | To receive sick leave pay toward my net income. Effective Date: | | | | | |  | |  | |
|  |  | | | | | |  | | | |
|  | I do not want to use any sick leave to supplement my workers’ compensation lost time payments. | | | | | | | | | |
|  | Effective Date: |  | |  | | | | | | |
|  | **I understand I am free to use accrued vacation and/or unused compensatory time as I choose with no reduction in my workers’ compensation weekly lost time payments.** | | | | | | | | | |
|  | **I understand that in electing to use accrued sick leave on a compensable injury, I am using sick leave that would otherwise be available later for a sickness or accident that is not job related. I also understand that by using sick leave for a compensable injury, I am using sick leave that would otherwise be available later to be applied to my creditable service time with the retirement system.** | | | | | | | | | |
|  |  | |  | | |  | | | |  |
| Employee’s Signature  (or lawful representative)\* | | |  | | | Date of Signature | | | | |
|  |  | | | | |  | | | | |
|  |  | |  | | |  | | | |  |
|  | Witness Signature | |  | | | Date of Signature | | | |  |
|  |  | | | | |  | | | | |
| The injured employee and/or lawful representative\* **refused** to sign this form. | | | | | | | | | | |
|  |  | |  | | |  | | | |  |
|  | Supervisor’s Signature | |  | | | Date of Signature | | | |  |
|  |  | |  | | | | | | | |
| \*The signature of representative of an injured employee is that of a duly authorized attorney, and attorney in fact with power of attorney, or, in the event of complete disability of the employee, the spouse of such employee. If the completely disabled employee has no spouse then the natural guardian in case of a minor or the legal guardian by appointment of a Probate Court is the lawful representative. EXHIBIT A | | | | | | | | | | |