

**WORKERS COMPENSATION LEAVE OF ABSENCE**

Employee Name                                 SS#   Company \_\_\_\_\_\_

Home Phone #:   Home Address:

Supervisor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location/Department

1. Requests should be submitted according to time frames outlined in the Workers Compensation Leave of Absence Policy and be received in Talent Management for approval or disapproval before leave commences.
2. Use of PTO/Plus-time or Workers Compensation Benefits may be elected. However, employee cannot receive both. Accrued PTO/Plus-time may be used for a maximum of twelve (12) weeks. After 12 weeks or exhaustion of available PTO/Plus-Time; the employee will receive workers compensation benefits.
3. All approved workers compensation leave of absences run concurrently with Family and Medical Leave entitlement.

**Start Date: End Date:**

**Workers Compensation Leave:**

**Reason**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Attach a copy of medical documentation****.*

**EMPLOYEE SELECTION: Information to Employees about a Leave of Absence:**

If approved for Workers’ Compensation Leave of Absence, I understand that I can receive compensation from available Time Off and Plus-Time OR receive worker’s compensation as defined by the state law.

**Please sign and date (a) or (b):**

**a)I have elected to receive compensation from my available Time Off and Plus-Time up to 12 weeks**

Employee Signature Date

**OR**

**b)I have elected to receive compensation as defined by the state workers’ compensation law**

Employee Signature Date

**I am informed of my option to continue or not continue health plan benefits or C.O.B.R.A.**

**coverage.**

Employee Signature Date

**I understand reinstatement applies to Medical, Workers’ Compensation, Family and Military Leave - may not apply to Personal Leave.**

Employee Signature Date

*I have been informed of my obligations, the impact of my leave of absence on benefits, reinstatement information and the requirements in connection with this approved leave of absence. I understand I am responsible for notifying my manager of my intent to return, seek an extension, or resign, two weeks prior to the above expiration. I understand I am responsible for communicating any other changes with Talent Management and my manager while on leave of absence.*

Employee Signature Date Supervisor Signature Date

Acknowledgement

VP, Talent Management Signature Date

Approved

President/CEO Signature Date