

WORKERS COMPENSATION PAYROLL AND INJURY LEAVE FORM

FROM: _____ (SUPERVISOR) print
DEPARTMENT: _____
DATE: _____
SUBJECT: _____ (EMPLOYEE) print
DATE OF INJURY: _____

The above named employee has received a work-related injury/illness and will be on injury leave:

Dates: _____

If the employee is not able to return to work after the injury dates have been exhausted they will be put on workers' compensation pay.

Starting Date: _____ at 66 2/3%

Workers' Compensation will not be paid to an employee who refuses light duty work.

I _____, understand that I will be on workers' compensation until released by the City's Physician. I also understand that, if I choose to receive the equivalent of a full paycheck after the initial injury leave period, I may use up to 33 1/3% of leave sick and/or vacation time that I would have normally worked.

_____ I wish to receive the equivalent of a full paycheck during my workers' compensation leave and hereby instruct the division to deduct 33 1/3% for each shift from my sick or vacation leave. **Once the FMLA period is over, City Policy requires that an employee use sick and vacation leave to supplement the 33 1/3% for each shift missed. (Exception would be PBA covered employees).**

_____ I do not wish to receive the equivalent of a full paycheck during my workers' compensation leave and hereby instruct the division not to deduct any time from my sick or vacation leave balance during my workers' compensation leave until my **FMLA period is over. City Policy requires that an employee use sick and vacation leave to supplement the 33 1/3% for each shift missed. (Exception would be PBA covered employees).**

IMPORTANT NOTICE: Employees, who elect not to supplement their workers' compensation leave with sick or vacation leave, must contact the City's finance department to arrange payment of the employee portion of any health, dental, and other group insurance premiums, and other payment obligations such as union dues, alimony and child support, etc.

Employee's Signature

Employee's Name (print)

Supervisor's Signature

Supervisor's Name (print)

Please send this report by email to:

- terrye.dexter@mlbfi.org
Risk Management Technician
- Give one copy to your divisional payroll department
- Give one copy to the Employee

IF you have any questions please call Risk Management at 608-7821

*****It is the employee's responsibilities to monitor his/her leave time*****