North Carolina State Government Workers’ Compensation Program

Employee Statement and Leave Options

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| Supervisors should provide all injured employees with this form to complete the information concerning the accident/incident and use of leave options for any time lost from work which may result from injury. Form should be completed in detail to give an accurate account of the case. Once form is completed by the employee, supervisor completes bottom portion and submits to agency WC Administrator. |
| **EMPLOYEE STATEMENT** |
| Name:       | SS#:       |
| Department:       |
| Division/Unit:       |
| Location:       | County:       |
| Date of Injury:       | Date Injury Reported:       |
| Name of Person Notified of Injury:       |
| Part(s) of Body Injured:       |
| Description of Accident:       |
| Cause of Accident:       |
| I understand the information above will be used by my employer to help determine liability for the injury. I acknowledge that the above statement is a true and accurate representation of this information. |
| Employee Signature: | Date:       |

**Use of Leave Options**

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| This is to certify that the use of leave options available in conjunction with the lost time from work as a result of an on-the-job injury which occurred on      , have been fully explained to me. I understand these options are available to me only if the agency determines the claim to be compensable and accepts liability. I understand that once I elect an option, that election shall be irrevocable as to each individual incident. After careful consideration, I elect the option(s) marked below. |
| **CLICK ONE OF THE CHECKBOXES BELOW TO SELECT AN OPTION** |
| [ ]  **OPTION 1** | Elect to take sick or vacation leave during the required seven-day waiting period and then go on worker's compensation leave and begin drawing workers' compensation weekly benefits. |
| [ ]  **OPTION 2** | Elect to go on workers' leave immediately with no pay for the seven-day waiting period and then began drawing workers' compensation weekly benefits. |
| **Note**: In either option above if the injury results in disability of more than 21 days, the workers' compensation weekly benefit shall be allowed from the date of the disability. |
| [ ]  **OPTION 3** | Elect to supplement the workers' compensation weekly benefit with the use of partial earned sick or vacation leave in accordance with the schedule provided by the Office of State Personnel. Use of the supplemental leave benefit applies only while drawing temporary total disability compensation. |
| **Note**: All elections involving the use of earned sick or vacation leave are subject to their availability at the time of the incident. |
| Employee Signature: | Division/Unit:       |
| UNCG ID#:       | Date:       |

**Supervisors Only**

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| The above-named employee was injured on       and was placed on workers' compensation leave on      . A Supervisor's Accident Report or Accident Investigation Report has been completed and is attached to the IC Form 19. |
| Supervisor’s Signature: | Date:       |