NORTH CAROLINA STATE GOVERNMENT WORKERS' COMPENSATION PROGRAM
EMPLOYEE STATEMENT AND LEAVE OPTIONS

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

Employee 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's Signature Date

Comment [OoSP1]: Form must be printed for signature on hard copy.

USE OF LEAVE OPTIONS

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.

Place an X in the space provided to select the option(s) you desire.

☐ **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

Comment [OoSP2]: Form must be printed for signature on hard copy.

_____ _____

Employee SS# Date

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Supervisor Completes This Section

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

Comment [OoSP3]: Form must be printed for signature on hard copy.