

**SELECTION OF PAYMENT OPTION**

Name of Injured/Ill Employee \_\_\_\_\_ Date \_\_\_\_\_  
(As shown on Payroll)

Job Title \_\_\_\_\_ Social Security # \_\_\_\_\_

Work Location \_\_\_\_\_ Work Phone # \_\_\_\_\_

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On \_\_\_\_\_ (Date), I was injured and/or became ill on the job while working for the \_\_\_\_\_ County Board of Health. I have been advised that if I have to lose any time from work because of this injury and/or illness that I will need to choose how I will be paid. I have been given the opportunity to read CBH Policy #1702, and have selected the following payment option:

(CHOOSE ONE ONLY)

( ) I have selected to use my accrued sick, annual and/or personal leave while absent due to my workers' compensation injury and/or illness. I understand that if I use all of my accrued leave, I will receive workers' compensation benefits if I am still unable to work. I have been advised that I cannot receive workers' compensation benefits and regular salary compensation (e.g. use of accrued leave) at the same time.

OR

( ) I have selected to receive workers' compensation benefits for loss of wages instead of using accrued leave. I understand that I will be placed on leave without pay while receiving workers' compensation benefits for loss of wages.

I understand that all absences from work due to an injury and/or illness that qualifies as a serious health condition will be charged to available family leave.

\_\_\_\_\_  
Signature of Injured and/or Ill Employee

MAIL TO: Department of Administrative Services  
Workers' Compensation  
P.O. Box 38198, Capitol Hill Station  
Atlanta, Georgia 30334-5529

(Copies of this form are to be provided to the appropriate District Personnel Office and your immediate supervisor.)