WAGE AND SICK LEAVE VERIFICATION
FOR WORKERS' COMPENSATION

EMPLOYEE'S NAME: _____

SSN: _____

SCHOOL / DEPARTMENT: _____

DATE OF ACCIDENT: _____

DATE DISABILITY BEGAN: _____

NUMBER OF DAYS OF ACCRUED SICK LEAVE: _____

*Please have the employee sign **one** of the following statements. By signing this form, the employee does not give up any rights to his/her claim.*

I, _____ CHOOSE TO USE MY ACCRUED SICK LEAVE IN LIEU OF WORKERS' COMPENSATION BENEFITS FOR LOST WAGES (**sick leave will **NOT** be reimbursed**).

I would like to use _____ days of my sick leave and _____ days of my vacation time.

_____
Date Signed by Employee

I, _____ CHOOSE TO CLAIM WORKERS' COMPENSATION BENEFITS FOR LOST WAGES IN LIEU OF USING MY SICK LEAVE.

_____
Date Signed by Employee

Employee's Supervisor: _____ _____
Signature / Date Printed Name

Payroll Department: _____ _____
Signature / Date Printed Name

IF YOU ARE OUT OF WORK SEVEN (7) CALENDAR DAYS OR LESS, SC LAW (SECTION 42-9-200) PROHIBITS THE PAYMENT OF WORKERS' COMPENSATION LOST WAGES.