FRISCO
INDEPENDENT SCHOOL DISTRICT

Employee Election to Use Paid Leave with Workers' Compensation Benefits

Name: _____
Employee ID# _____
Position: _____
Department/Campus: _____
Date of Injury: _____
This employee is absent from duty because of a work-related illness or injury beginning on_____.
If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

Please select and complete at least one of the following. This information must be completed as you are confirming that the employee will receive full pay during this time and there will be no loss of wages.

1. _____ # of **days** of leave available OR
2. _____ # of **hours** of leave available OR
3. The date that available leave will expire on is: _____

Dafne Rodriguez
District Authorized Signature **DATE**

Employee choice:

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I voluntarily use this option until I tell you otherwise.
I choose the following option:

1. _____ I choose to use only _____ days of available paid leave at this time.

2. _____ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness or –injury wages. I further understand that my leave will continue to be used unless and until I communicate to the district a change in my decision.

3. _____ I choose **NOT** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from **FRISCO** ISD while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will only receive workers' compensation wage benefits for any absences resulting from my work-related illness or injury, after exceeding seven days of lost time, unless and until I communicate to the district a change in my decision.

_____ _____
Employee Signature **Date**