



THE TEXAS A&M UNIVERSITY SYSTEM WORKERS' COMPENSATION
INSURANCE

REQUEST FOR PAID LEAVE

Please forward promptly within the first seven days after an injury resulting in loss time.

Name of Employee

Social Security #

Date of Injury

Claim Number
If known

IF YOU SUSTAIN A DISABLING ON-THE-JOB INJURY COVERED BY WORKERS' COMPENSATION INSURANCE, YOU MAY REMAIN ON THE PAYROLL UNTIL YOUR ACCRUED PAID LEAVE IS EXHAUSTED. IF YOU HAVE NOT BEEN RELEASED TO RETURN TO WORK BY YOUR TREATING DOCTOR AFTER ACCRUED LEAVE IS EXHAUSTED, YOU WILL BE PLACED ON LEAVE WITHOUT PAY. WORKERS' COMPENSATION WEEKLY WAGE REPLACEMENT BENEFITS, AS PRESCRIBED BY STATUTE WILL BE INITIATED.

TOTAL LEAVE AVAILABLE	DAY	HOURS
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I wish to use all of my accrued paid leave to remain on the payroll from _____ through _____. After such time *workers' compensation weekly wage replacement benefits* will begin, provided I have not been released to return to work by a doctor.

I wish to use a portion of my accrued paid leave in order to remain on the payroll from _____ through _____. After such time *workers' compensation weekly wage replacement benefits* will begin, provided I have not been released to return to work by a doctor.

I do not wish to use any portion of my accrued paid leave to remain on the payroll. Therefore, I will be placed on leave without pay. *Workers' compensation weekly wage replacement benefits* will begin on the 8th day of disability resultant from my work related injury, provided I have not been release to return to work by a doctor.

Injured employee's signature, or signature of person obtaining information

Date

