Dallas County Human Resources/Civil Service Department
Workers Compensation Leave Authorization Form

Name	_____	Social Security Number	_____
Department Name	_____	Department Number	_____
Supervisor Name	_____	Office Phone	_____
Time/Attendance entered by	_____	Home/Mobile Phone	_____

Election to receive pay in addition to mandated Temporary Income Benefits (TIBs) ***Check one option***

Option 1 ☐	I would like the Auditor=s Office to calculate the amount needed to provide the difference between my TIBs check and my regular paycheck. I understand that time will be deducted from my current sick leave balances to provide this benefit. When my sick leave is exhausted, I would like (*check one)*: ☐ to use _____ hours of my current accumulated annual leave time each pay period until my leave balance is exhausted. (Hours not to exceed full pay period); or ☐ to not use any accrued annual leave.
Option 2 ☐	I do not want to use any of my leave balances to supplement TIBS. I understand that I will be required to pay insurance premiums or risk having my insurance canceled. I also understand any additional deductions from my regular paycheck will be my responsibility.

Statements of Understanding ***Initial Each Statement***

_____ I understand I do not earn sick leave, vacation leave or holiday pay while I am receiving workers compensation benefits.

_____ I understand I will be placed on FMLA, if eligible, that it will run concurrently with workers compensation, and that I will be billed for insurance benefits each period I do not receive wages at least equal to my deductions.

_____ I have received a copy of the current workers compensation policy and procedures and that additional information regarding the County Code is available at www.dallascounty.org.

_____ I understand that failure to return this form within 24 hours of injury may result in non-payment for authorized leave in the current period, with no retroactive adjustments.

_____ I understand these elections are in effect and may not be changed for the duration of this injury.

Insurance Election ***Check one statement only***

_____ I elect to maintain existing insurance coverage. I will remit payment in a timely manner for all insurance coverage as billed every thirty (30) days.

_____ I elect to suspend dependent and optional insurance coverage and understand that I will be subject to a thirty-day (30) waiting period upon reinstatement.

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

<u>To be completed by the Auditor's Office</u>

<u>Leave Balances</u> ***Sick*** _____ ***Vacation*** _____ ***Comp*** _____

Date of Injury _____ ***AMA Approved Leave*** _____

White Copy – Risk Management Yellow Copy – Auditor Pink Copy – Department Gold Copy - Employee