Workers Compensation Leave Form and Employee Injury Report

Any full-time County employee absent from duty because of sickness or disability covered by the North Carolina Workers Compensation Act ("NCWCA") may receive workers' compensation benefits and will use their accumulated leave as a supplemental payment for the difference between his regular salary and the payments received under the NCWCA.

To be eligible for any lost wage benefits under the NCWCA an employee must: (1) be injured while in the service of their employer, (2) be written out of work by a licensed physician, and (3) be out of work for an initial seven day period.

Once the initial seven day period has passed an employee will be eligible for lost wage benefits, but must complete and submit the following form. Submission of this form will allow the employee to begin receiving workers' compensation checks to cover two-third (2/3) of his her salary. The remaining 1/3 will be recouped by using the employee's accrued leave until all the employee's leave is exhausted. This will result in an employee using one (1) entire day of leave for every three (3) days an employee remains on workers' compensation.

While on workers' compensation leave an employee will continue to accrue all forms of leave as addressed in Article IV of the Harnett County Personnel Ordinance. FMLA leave will run concurrently with any employee's workers' compensation leave and will count against that employee's allotted 12 weeks of FMLA leave. Additional information on workers' compensation may be found in the Harnett County Personnel Ordinance at Article VI, Section 8.

Employee name: _____(_____)
Last First Middle (Maiden)

Social Security Number: _____ -- _____ -- _____ **Date of Birth:** _____ /_____ /_____

Street Address: _____
Street City State Zip

Phone: (_____) _____ -_____ **Alternate Phone:** (_____) _____ - _____

Department: _____ **Title:** _____ **Supervisor:** _____

Accident Date: _____/_____/_____ **Shift Start Time:** _____:_____ **Accident Time:** _____:_____

Reported Date: _____/_____/_____ **Reported Time:** _____:_____

Person(s) Notified of Accident: _____

Current Work Status: ☐ Out of Work (Last Day Worked: _____/_____/_____)
☐ Working With Restrictions (Restrictions: _____)
☐ Working without Restrictions

Brief Description of Illness/Injury:

Treatment Information: ☐ Treated at Lillington Family Medical Center
☐ Treated at other facility (_____)
☐ Taken to Hospital by Ambulance
☐ Refused Treatment

By signing below I acknowledge that all the information contained on this form is a true and correct representation and I am not, nor will I ever, provide the County with false information.

_____

Employee Signature **Date**

_____

Supervisor/Department Head Signature **Date**