LEAVE ELECTION FORM

DATE: _____

TO: DOAS/Division of Risk Management Services
Worker's Compensation Unit
P.O. Box 38198, Capitol Hill Station
Atlanta, GA 30334

FROM: _____
(Injured Employee's Name-Please Print)

_____
(Date of Injury)

_____
(Contact Number)

RE: Workers' Compensation Payments

If the Injury which occurred is a work-related injury, the Georgia Workers' Compensation Law states that you may be entitled to compensation equivalent to 66 2/3% of your average weekly earnings up to a maximum of $500.00 per week for time lost from work due to that injury, if your absence from work is recommended by an authorized