

Workers' Compensation Program Leave Supplement Form

Minnesota State Statute benefits pay for time missed from work at 2/3 of my average weekly pay. As an employee of the State of Minnesota, I understand if I get workers' compensation benefits, I can choose to add my unused sick leave, vacation time or compensatory time to help increase my pay while receiving benefits back to the full amount. Sick leave must be used first before using any other compensatory time.

I understand that if I use this extra leave, my leave time will be added up from the hours paid by workers' compensation, the hours I use for sick, vacation, or compensatory time, and the regular hours I work.

If I am off work and my leave is used up, I understand that I will no longer be able to add extra leave or keep getting leave time in the next pay periods.

I know I can change my mind about using extra leave. To do this, I just need to fill out this form when I make the change.

If I choose not to use extra leave, and I can't work, I will need to ask for unpaid medical leave. If I take unpaid leave, I won't earn sick or vacation time.

If I come back to work with fewer hours and still use extra leave with workers' compensation, my leave time will be based on the total hours from the workers' compensation, the hours I worked, and the hours I used for leave.

If I come back to work with fewer hours and don't use extra leave, my leave time will only be based on the hours I worked and the hours I get from workers' compensation.

_____ I want to use sick leave _____ vacation leave _____ or compensatory time to add to my workers' compensation benefits.

_____ I do not want to use sick leave, vacation time, or compensatory time to add to my workers' compensation benefits.

_____ I want to keep using sick leave, vacation leave, or compensatory time to add to my workers' compensation benefits while working fewer hours.

_____ I do not want to use sick leave, vacation leave, or compensatory time to add to my workers' compensation benefits while working fewer hours.

Employee Name (Print) _____ **Employee ID #** _____ **Date of Injury** _____

Employee Signature _____ **Date** _____