Exhibit

WAGE AND SICK LEAVE VERIFICATION FOR WORKERS' COMPENSATION

Code **EGAA-E** *Issued* **08/23/02**

EMPLOYEE'S NAME: _____ SSN: ____ - __ - ____

SCHOOL/DEPARTMENT: _____

ACCIDENT: __/__/__ DATE DISABILITY BEGAN __/__/__

NUMBER OF DAYS OF ACCRUED SICK LEAVE: ____
(Risk Management has access to this information)

Please have the employee to sign <u>one</u> of the following options. By signing this form, the employee does not give up any rights to his/her claim.

<u>OPTION ONE</u>

I, _____ *(print name)* choose to use my accrued sick leave in lieu of worker's compensation benefits for lost wages. **Sick leave will no longer be reimbursed.**

Once my sick leave has been depleted, I elect to convert over to worker's compensation benefits.

☐ YES ☐ NO ☐ N/A

Signature: _____ Date: __/__/__

<u>OPTION TWO</u>

I, _____ *(print name)* choose to claim worker's compensation benefits for lost wages in lieu of using my sick leave.

Signature: _____ Date: __/__/__

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(The employee's supervisor must sign this form.)

Employee Supervisor's Signature: _____

Print Name: _____ Date: __/__/__

IF YOU ARE OUT OF WORK SEVEN (7) CALENDAR DAYS OR LESS, SOUTH CAROLINA LAW PROHIBITS PAYMENT OF LOST WAGES.