



PAYROLL OFFICE

1st Floor, Carlotti Administration Building, Kingston, Rhode Island 02881-0819

Date: _____

I, _____ SS# _____,
(Name of Employee)

request the following pending a determination from the Department of Workers'

Compensation for my work related accident that occurred on _____.

I understand that the first 3 days of lost time from work, due to my work-related injury is considered non-compensatory time and I can use personal, vacation, sick time, etc. Beginning the 4th day out due to this work-related injury I choose the following:

Do not use my sick time

I have no sick time to use

Use my sick time*

***By choosing this option I agree to the following:**

***Upon approval from Workers' Compensation, I agree to reimburse the University of Rhode Island the amount received on the biweekly payroll for the pay period paid by Workers' Compensation.**

***Reimbursement will be through deductions made to subsequent biweekly earnings.**

***The net amount reimbursed to the University will probably exceed the amount received from Workers' Compensation.**

***Reimbursement will result in a restoration of any sick time discharged.**

If my claim is denied by Workers' Compensation, I agree to accept the salary that I have been paid and the charge to my sick leave.

Employee's Signature

Date

Rev. 8-30-04