

EMPLOYEE'S STATEMENT

NAME _____

DATE OF INJURY _____

PLEASE EXPLAIN WHEN, HOW, AND WHERE ACCIDENT OCCURRED AND INJURIES RECEIVED:

(If additional space is needed, attach a separate sheet.)

1. **Use of Time** – If you lose time from work, you may choose one of the following:
 - A. Elect to take earned sick leave during the required waiting period and then go on workers' compensation leave and begin drawing workers' compensation weekly benefits.
 - B. Elect to go on workers' compensation leave with no pay for the required waiting period and then begin drawing workers' compensation weekly benefits.
 - C. Elect to supplement the workers' compensation weekly benefits with the use of partial earned sick leave in accordance with the State Board of Education Workers' Compensation Policy.
- Note:** All elections involving the use of earned sick leave are subject to their availability.
2. **Waiting Period** – No compensation shall be paid for the first seven days of disability unless the disability continues for more than 21 days. (Sick leave may be used for the first seven days.)
3. **Workers' Compensation Rate** – Two-thirds of your average weekly wage during the 52 weeks preceding the date of the injury not to exceed the maximum amount established by the North Carolina Industrial Commission.
4. **Medical Services – Referrals** – If necessary, or if you wish you may go to Wilson Immediate Care, Forest Hills Immediate Care or Family Medicine. You should never go to the emergency room unless absolutely necessary or if the initial doctor refers you to the emergency room. The only way you may go to another doctor other than the initial attending doctor is if the initial doctor or the N.C. Industrial Commission refers you to a specialist.
5. **Nursing Services** – Nursing services are provided only at the request of the treating physician. Note: Housekeeping services in your home and/or childcare are not considered nursing care.
6. **Prescription Drugs** – All prescription drugs must be on Form 25P giving name of doctor, name of drug, claimants' social security number and receipts attached before reimbursement can be made.
7. **Travel** – Employees are entitled to mileage for medical treatment at the rate of 31 cents per mile beyond a 20 miles radius (round trip) from point of origin. (Form 25T must be completed for reimbursement.)

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THE RULES SET OUT TO BE FOLLOWED IN THE HANDLING OF MY CLAIM.

Signature of Employee

Date

Witness