NORTH CAROLINA STATE GOVERNMENT WORKERS’ COMPENSATION (WC) PROGRAM
EMPLOYEE STATEMENT, LEAVE OPTIONS & MEDICAL AUTHORIZATION/RELEASE FORM

Supervisors should provide all injured employees with these forms to complete the information concerning the accident/incident and use of leave options for any time lost from work that may result from injury. The Forms should be completed in detail to give an accurate account of the case. After completion of the leave options, the supervisor completes bottom portion and submits it to NCCU’s WC Administrator (Catherine Allsbrook x-7943).

EMPLOYEE STATEMENT

Employee Name: ___________________________ Banner ID ___________________________

□ Female □ Male Date of Birth: __________

Address: ___________________________ City, State & Zip: ___________________________

Phone(s): Home ( ) Work ( ) Mobile ( )

Occupation: ___________________________ Department: ___________________________

Division & Unit: ___________________________ Supervisor: ___________________________

Date & Hour of Injury: ___________ □ AM □ PM

Date Injury Reported: ___________ Name of Person Notified of Injury: ___________________________

□ On or □ Off Campus Specific Location: ___________________________

List all injuries and specify body part involved (e.g. right hand or left hand)

Part(s) of Body Injured: ___________________________

Describe fully how injury occurred and what the employee was doing when injured and witnesses

Description of Accident: ___________________________

Describe potential causes of the accident and possible methods of prevention

Cause of Accident: ___________________________

__________________________________________
Employee's Signature

__________________________________________
Date
USE OF LEAVE OPTIONS

This is to certify that the use of leave options available in conjunction with the lost time from work as a result of an on-the-job injury which occurred on __________ (date) have been fully explained to me. I understand these options are available to me only if the agency determines the claim to be compensable and accepts liability. I understand that once I elect an option, that election shall be irrevocable as to each individual incident. After careful consideration, I elect the option(s) marked below.

Place an X in the space provided to select the option(s) you desire.

☐ Option 1: Elect to take sick or vacation leave during the required seven-day waiting period and then go on worker's compensation leave and begin drawing workers' compensation weekly benefits.

☐ Option 2: Elect to go on workers' leave immediately with no pay for the seven-day waiting period and then began drawing workers' compensation weekly benefits.

   Note: In either option above if the injury results in disability of more than 21 days, the workers' compensation weekly benefit shall be allowed from the date of the disability.

☐ Option 3: Elect to supplement the workers' compensation weekly benefit with the use of partial earned sick or vacation leave in accordance with the schedule provided by the Office of State Personnel. Use of the supplemental leave benefit applies only while drawing temporary total disability compensation.

   Note: All elections involving the use of earned sick or vacation leave are subject to their availability at the time of the incident.

__________________________________________________________________________

Employee Signature                      Division/Unit

__________________________________________________________________________

Employee Banner ID #                      Date

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Please speak with Cathy Allsbrook about the Use of Leave Options if you are unsure which leave option may best suit your needs.
NORTH CAROLINA CENTRAL UNIVERSITY
- Medical Authorization/Release Form

I hereby authorize Corvel Corporation, the N.C. Attorney General’s Office, and any assigned rehabilitation or vocational rehabilitation specialist bearing this release (or a photocopy of same) to obtain medical information from my files. I hereby direct you to release such information upon the request of the bearer. This release is executed with full knowledge and understanding that the information is for official use regarding my workers compensation claim with the North Carolina Industrial Commission. Consent is also given to allow my employer to release medical information to the above listed individuals for use with my workers compensation claim. I hereby release you, including your employees, as custodian of my medical records from any and all liability for damages of any kind which may at any time result to me, my heirs, family or associates because of compliance with this authorization and request to release information, or any attempt to comply with it. The bearer of this release agrees not to release this medical information to individuals not associated with my workers compensation claim. Should there be any questions as to the validity of this release, you may contact me as indicated below.

Full Name: ___________________________ (Signature) ___________________________ (Date)

(Printed Name)

Banner ID #: ___________________________

Current Address: ___________________________

(Street and Apt.) ___________________________

(City, State & Zip)

Telephone Number: ( ) ___________________________ ( ) ___________________________

(Home) ___________________________ (Work)