NEBRASKA
Good Life. Great Service.
DEPT. OF ADMINISTRATIVE SERVICES

Request to Supplement Workers' Compensation Benefits

Employee must complete this form promptly after an injury resulting in lost time.

1. Employee Name (printed)	2. Date of Injury
3. Social Security Number xxx-xx-	4. Claim Number

If you sustain a disabling on-the-job injury/illness covered by workers' compensation, you may choose to have your workers' compensation benefits supplemented with leave time you have accrued. An employee may use sick, vacation, injury leave, or comp time. If an employee does not have any leave time available, the employee will only receive statutory workers' compensation benefits. An employee may also elect not to supplement workers' compensation benefits with leave time. The choice to supplement benefits may be rescinded by the employee at any time.

5. Total Leave Available:

Sick Hours:	Vacation Hours:
Injury Leave:	Comp Time:

☐ 6. I wish to use all of my accrued sick leave.
☐ 7. I wish to use all of my accrued vacation leave.
☐ 8. I wish to use all of my injury leave.
☐ 9. I wish to use all of my accrued comp time.
☐ 10. I wish only to use _____ hours of _____leave.
☐ 11. I do not wish to supplement by workers' compensation benefits with leave time.

_____
Date

_____
Employee's Printed Name

_____
Employee's Signature

☐ 12. I wish to rescind the selections identified above. I no longer wish to have my workers' compensation benefits supplemented with leave time.

_____
Date

_____
Employee's Printed Name

_____
Employee's Signature