

Human Resources Department  
ON-THE-JOB-INJURY PROGRAM  
Authorization for Wage Payment

Employee name: \_\_\_\_\_

PR # : \_\_\_\_\_

Department: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Per the attached certificate the above employee is medically restricted from work due to a work related injury from:

\_\_\_\_\_ until \_\_\_\_\_

The employee has elected to receive:

∩ 2/3rds average earnings

↑ 100% average earnings \*

\* Subject to completion of sick/annual leave authorization below.

**SICK/ANNUAL LEAVE USE AUTHORIZATION:**

Under the provisions of Montgomery County Personnel Procedures, I wish to supplement the 2/3rds of earnings paid to employees restricted from work due to an on the job injury with my accumulated sick or annual leave time until exhausted, which will allow me to receive 100% of my regular earnings.

I understand that I will be required to sign a leave slip (s) for the required leave time needed to supplement my earnings to 100%.

Estimated number of hours required: \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Departmental Representative

Please attach doctor's certificate and forward to the Risk Management Section of the Human Resources Office.

If you have any questions, please call 648-5715.