WORKERS' COMPENSATION RELEASE FORM

I,
hereby agree to accept salary continuance from my employer, the City/Town of

in lieu of the temporary lost-wage benefits to which I would otherwise be entitled in accordance with Arizona's workers' compensation statutes. B y accepting salary continuance from my employer, I further authorize the payment of the temporary disability workers' compensation benefits I would otherwise receive to be sent directly to my employer.

I understand the salary continuance I receive from my employer may be taxable as income even though any temporary disability benefits I would otherwise receive in accordance with Arizona's workers' compensation statutes are not taxable as income.

I hereby authorize Southwest Risk Services, administrator for my workers' compensation insurance provider, the Arizona Municipal Risk Retention Pool (AMRRP), to mail any temporary disability checks which I would otherwise receive for time lost from work due to an industrial injury to:

The City/Town of

Employee Signature

Witness

Injury Date:

Dated this day of , 20

cc: Southwest Risk Services

City/Town of Payroll