

CITY OF STOCKTON
INTEGRATION ACKNOWLEDGEMENT FORM

OPTION TO DECLINE

I have read and understand the attached explanation of the City of Stockton's Integration Policy. I understand this policy relates to lost work time as a result of work related injuries. I understand that the choice to Integrate is presumed without an acknowledgement to decline to Integrate. **If I initial the line below**, I am providing acknowledgement that I do not want to participate in Integration. If I **do not** initial the line below declining participation, I understand I will be required to follow the Integration process.

I am filing a Workers' Compensation Claim with the City of Stockton for the date of

_____ with _____.
(Date of Injury) (Department)

_____ I am choosing not to integrate my workers' compensation benefits with my accrued benefits. I understand, if I lose more than three days of work time and my claim is accepted, I will only receive temporary disability benefits based on my average weekly wage. I am choosing not to use my accrued benefits to supplement any temporary disability I may be due. I further understand this decision is binding and may not be reversed at a later date.

Acknowledgement of receipt of Integration Policy and Opportunity to Opt Out of participation:

Name of Employee (Print)

Employee Signature

Date of Signature