STATE OF HAWAIʻI | KA MOKUʻĀINA O HAWAIʻI
DEPARTMENT OF HUMAN RESOURCES DEVELOPMENT
KA ʻOIHANA HOʻOMŌHALA LIMAHANA
235 S. BERETANIA STREET, ROOM 1300
HONOLULU, HAWAIʻI 96813-2437

Accident Injury Leave Election Form

(To be completed by the employee)

Name (employee):	
Department:	Date of Injury:
Were you on duty at the time of the accident: ☐ YES ☐ NO	

Describe in detail, circumstances that caused your accident:

Elect one of the following:

☐ YES ☐ NO **ACCIDENTAL INJURY LEAVE (AIL)**

If approved, you will receive 100% of your regular monthly salary for the first four (4) months (120 days) of disability. Should the disability continue beyond four months, you will continue to receive accidental injury leave at 60% of your basic rate of pay.

☐ YES ☐ NO **TEMPORARY TOTAL DISABILITY (TTD)**

If approved, you will receive temporary wage replacement benefits equal to 66 and 2/3% of your average weekly wage, but no more than the weekly maximum benefit amount under Chapter 386, Hawaii Revised Statutes.

☐ YES ☐ NO **AIL FOLLOWED BY TTD**

If approved, you will receive AIL for the first four (4) months (120 working days). After four (4) months of AIL, you will receive temporary wage replacement benefits equal to 66 and 2/3% of your average weekly wage, but no more than the weekly maximum benefit amount under Chapter 386, Hawaii Revised Statutes.

I certify the above is true and correct to the best of my knowledge.

_____ _____

Employee signature Date

DHRD/ECD 11/2025

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