

## Reinstatement of Leave Entitlements

### Declaration from Employee:

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I ..... undertake to pay to my employer  
(Name of Employee)

..... Disability Allowance payments as made by  
(Name of Employer)

the MAIB in order to reinstate leave entitlements received in the period of

..... to ..... within seven (7) days of having received the  
(Date employer has paid from) (Date employer has paid to)

payment from the MAIB for that period.

Signed: ..... Dated: .....  
(Employee)

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### Declaration from Employer:

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We .....undertake to accept payment from  
(Name of Employer)

..... in order to reinstate leave entitlements paid  
(Name of Employee)

whilst incapacitated from employment as a result of injuries sustained in the motor accident of

..... 20 . We understand that payment will be received by us within  
seven (7) days of the MAIB having made the payment for the period.

Signed: ..... Dated: .....  
(Employer Representative)

Full Name: ..... Position Held in Company: .....

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*Please note that the MAIB requires confirmation from the employer upon receipt of monies made by employee.*

*This confirmation can be made by telephoning the MAIB on 1800 006 224 or (03) 6336 4800.*