WORKERS' COMPENSATION MEDICAL CARE PLAN

EMPLOYEE

RIGHTS AND RESPONSIBILITY

I _____ attest that I have read and understand the
Print name

Employee Instructions stating that I must seek treatment, for any work related injury, from a provider of my choice from within the Workers' Compensation Trust provider network.

I understand that if I choose to seek treatment from a physician or provider not listed in the provider directory for a specialty covered by the network, I put my Workers' Compensation claim in jeopardy and may be responsible for the cost of my treatment.

_____

Signature

_____

Date