WORKERS' COMPENSATION ACKNOWLEDGEMENT FORM

I,____, received the following notices and forms
(Name)

for date of injury ________________________:
(mm/dd/yy)

☐ Medical Records Release Form

☐ Workers' Compensation Claim Form (where applicable)

☐ Medical Provider Network Packet (CA Only)

☐ ____
(Other)

I have been offered medical treatment and choose to (check option):

☐ Decline at this time but will notify my Supervisor if my situation changes

☐ Accept and go to our Preferred Medical Provider

____
(Signature)

____
(Print Name)

____
(Date)