Worker's Compensation Acknowledgment

Instructions: Please read this acknowledgement and complete the bottom portion.

My signature below indicates that I have been advised that as a state employee I am covered by the Georgia Workers' Compensation Law. I understand that I am to immediately report all on-the-job injuries regardless of the extent of the injuries to my supervisor or manager. I realize that a delay in notification can result in denial of payment for any medical services rendered.

I understand that if I am injured while on the job and emergency treatment is necessary, I will receive emergency treatment as soon as possible. All follow up care, however, must be received through the Managed Care Organization listed on the **OFFICIAL NOTICE** which is posted in my work area.

I further understand that I must receive all non-emergency treatment through the Managed Care Organization listed on the **OFFICIAL NOTICE**. If I obtain non emergency medical treatment from outside the Managed Care Organization, I will be responsible for the medical expenses.

I understand that during my treatment, I am expected to provide to my supervisor of Human Resources written medical updates from my treating physician each time I have a medical appointment related to my injury.

During my treatment, I acknowledge that I may change to another authorized treating physician one time by contacting the Managed Care Organization. Any further change of physician will require the approval of Risk Management and the Nurse Case Manager.

I understand that any questions I have regarding the above information should be discussed with my supervisor or Human Resources.

Employees Signature			
Printed Name		**Date**	