

**EMPLOYEE ACKNOWLEDGEMENT
REGARDING PHYSICIAN SELECTION
IN NON-EMERGENCY SITUATIONS**

I, _____(employee Name), acknowledge that I have notified a supervisor or other person in a position of authority of an injury, and that I have elected to seek treatment for this injury from _____(medical provider name) from the providers listed on the Workers' Compensation Panel of Physicians posted at my place of employment.

SIGNATURE: _____ DATE: _____