EMPLOYEE NOTIFICATION FORM

WORK RELATED INJURY OR ILLNESS

(this is to be signed and retained in the personnel file of the employee)

I have been notified by my employer of the procedure to follow in the event I have a work-related injury or illness. I understand that my employer has a designated medical provider for all work-related injuries and illness. I understand that if I do not receive my medical care for work-related injuries and illness from the **DESIGNATED MEDICAL PROVIDER,** I can be held financially responsible for that care.

I understand, in an emergency situation, I may go to the nearest emergency facility and that my follow-up medical care should be provided by the **DESIGNATED MEDICAL PROVIDER.**

I have been notified that I must advise my supervisor in writing of any work-related injuries and illnesses within 24 hours of the accident, pursuant to section 8-43-102 (1) and (1.5), C.R.S. I will obtain a written authorization from my supervisor before seeing the doctor.

If my injury requires follow-up treatment or doctor visits, I understand it is my responsibility to immediately notify my supervisor of the results of each doctor visit, and any restrictions I may have as a result of the injury. I also understand the requirements of the Return-to-Work program in place.

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Signature of Worker

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Signature of Supervisor/HR Representative

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Date