EMPLOYEE TRAINING ACKNOWLEDGEMENT FORM

Employer Name:_____

Employee Name:_____
Last First M.I.

Employer Department:_____

In signing this document, I acknowledge that I have received University educational training materials for the Workers Compensation Medical Care Plan.

I also acknowledge that I have received the Employee Information Notice describing this Workers Compensation Medical Care Plan. I realize that I risk suspension of my workers compensation benefits if I do not use medical providers within the designated medical network.

Employee Signature:_____

Employee Name (Print):_____

Date:_____

Manager/Supervisor Name_____