COBB & DOUGLAS
PUBLIC HEALTH

ACKNOWLEDGMENT OF WORKERS' COMPENSATION TREATMENT

My signature below indicates that I have been advised that as an employee of the Cobb County Board of Health/Douglas County Board of Health, I am covered by the Georgia Workers' Compensation Law. I have been informed that I am to immediately report all on-the-job injuries **regardless of the extent of the injuries** to my supervisor, HR/Personnel Representative or other authorized official. 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 provided by a Workers' Compensation physician listed on the **OFFICIAL NOTICE, which** is posted in my work area.

I further understand that if emergency treatment is **NOT** necessary, I must receive treatment from a Workers' Compensation physician listed on the **OFFICIAL NOTICE**. If I obtain non-emergency medical treatment from a physician not on the **OFFICIAL NOTICE**, I will be responsible for any medical expenses.

I have been advised that if I am dissatisfied with the physician selected, I may make one change without permission to a second physician on the **OFFICIAL NOTICE**. Any further changes of physicians will require the permission of the Office of Human Resource Management or the State Board of Workers' Compensation.

If I have questions regarding the above, I should discuss them with my supervisor or other authorized official.

_____ _____

Signature of Employee Date

_____ _____

Signature of HR/Personnel Representative/Supervisor/ Other Authorized Official Date