Alexandria City Public Schools

AUTHORIZED PANEL OF PHYSICIANS ACKNOWLEDGEMENT & SELECTION FORM

Read the instructions carefully: Select a physician from the Authorized Panel of Physicians, complete this form, then submit to your supervisor (or designee).

THIS FORM MUST BE SUBMITTED ALONG WITH THE NOTICE OF INJURY/ILLNESS & INVESTIGATION FORM

The Virginia Workers' Compensation Act allows you to select a treating physician for your work related injury/illness from a list of physicians approved by Alexandria City Public Schools (ACPS). A list of approved physicians in the most common specialties is available from your supervisor. If your medical condition requires a physician in a specialty not included on the list, ACPS' third part administrator, CorVel, will provide a referral.

If you require immediate care, you must be treated by the urgent care provider identified on the Authorized Panel of Physicians. In a serious emergency, go the closest emergency facility. Any follow-up care must be obtained from a physician on the Authorized Panel of Physicians. If you want to change treating physicians, you must first obtain permission from CorVel.

ACPS will not pay for medical care provided by a physician not on the Authorized Panel of Physicians or otherwise approved by CorVel.

Employees who experience a workplace incident must report the incident by contacting CorVel at **877 764-3574** and complete and submit to Human Resources the Notice of Injury/Illness & Investigation Form and the Authorized Panel of Physicians Acknowledgement and Selection Form.

THIS SECTION TO BE COMPLETED BY EMPLOYEE

☐ Yes I have read the above instructions and have contacted CorVel.

☐ Yes I have received a copy of the ACPS Authorized Panel of Physicians.

☐ Yes I have selected/will select a physician from the Authorized Panel as my treating physician

_____
Physician Selected (Print Name)

☐ Yes I understand that I may only change physicians with prior approval from CorVel.

____ I decline to select a physician from the Authorized Panel of Physicians. I understand that I will have to pay for any medical treatment or doctor's bill, and that I may be denied workers' compensation for any absence based on a disability that is not certified by a physician from the Authorized Panel of Physicians. I also understand that I cannot use my personal health insurance to pay for costs associated with my workplace injury.

_____	_____	_____
Employee Name (PRINT)	Employee Signature	Date
_____	_____	_____
Supervisor Name (PRINT)	Supervisor Signature	Date