DeKalb County School District

Risk Management

I,_____, confirm that I 'am a Dekalb County School District (herein DCSD) employee and I reported injuries to the following body part(s):_____On the following date: _____ , 2023.

I reported my injury to Mr./Ms. _____On_____.

I was shown and reviewed a copy of the attached Employer's panel of physicians, which is enclosed with this document. I confirm, acknowledge, and understand that I have the right to select a doctor of my choice from that panel to evaluate my alleged work injuries. Despite my Employer's instructions to select the physician of my choice from the physicians listed on the posted panel of physicians, I have elected to: (Please check the box that applies)

- ○ I was advised that I am required to complete and Employer's Accident Report after reporting a potential work injury to my supervisor. I am refusing to fill out an Employee Accident Report at this time;
- ○ Not pursue treatment for this alleged injury; or
- ○ Treat with the following physician to address the injuries referenced above: Dr. _____. I understand that this doctor is not listed on my Employer's panel of physicians, and he/she is <u>not an approved</u> medical provider for my employer's workers' compensation program.

  It has been explained to me that any and all medical treatment provided by a doctor/physician that is not listed on my Employer's panel of physicians may be controverted, and I may be responsible for the cost of the medical treatment.

  I understand that my decision to not treat with a physician on the Employer's posted panel of physicians could result in the denial of workers' compensation benefits (indemnity and/or medical benefits).

_____ _____

Employee Signature Date

_____ _____

Witness (please print name and job title) Date

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