

EMPLOYEE AGREEMENT EMPLOYEE SAFE WORKING PRACTICES/MANAGED CARE

As a condition of employment, I _____ do hereby agree to comply
(Please print full name)
with the following Employee Safe Working Practices and Managed Care Program.

1. I agree to follow established departmental safety procedures.
2. I agree to report any work-related accident or injury to my supervisor as soon as it occurs, but no later than the end of my duty shift.
3. If I need treatment for a work-related injury, I understand that my employer has enrolled in a Managed Care Program for Workers' Compensation with **FHM Insurance Company WECARE program and AmeriSys/Rockport Network** and that the following procedures must be followed for all work-related injuries and illnesses. It is important to note that Florida Statute 440.134(17) states "**Treatment received outside the Workers' Compensation managed care arrangement is not compensable unless authorized by the carrier prior to the treatment date.**"
 - ✓ Report promptly any work-related injury to supervisor.
 - ✓ Hand carry the Introductory Letter to Physician to the Medical Care Coordinator on the initial visit.
 - ✓ Follow the Medical Care Coordinator's instructions for any additional specialist treatment, if needed.
 - ✓ **Ensure all medical treatment is handled only through the Medical Care Coordinator.**
 - ✓ Direct all questions about level of care to the Medical Care Coordinator, who is the focal point for medical treatment.
 - ✓ Follow established Grievance Procedures to resolve any dissatisfaction with medical treatment.

I understand that failure on my part to follow the above procedures could result in disciplinary action not to exclude termination and loss of Workers' Compensation benefits.

I also understand that according to Section 440.09(5) of the Florida Workers' Compensation Law, my compensation benefits could be reduced for any injury that occurs because of failure to follow established safety procedures.

Employee Signature

Date

Witness Signature