

**EMPLOYEE AGREEMENT
EMPLOYEE SAFE WORKING PRACTICE/MANAGED CARE**

As a condition of employment, I _____ do hereby agree to
(Please print full name)
comply 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 WE CARE Program and AmeriSys/Coventry Network*** and that the following procedures must be followed for all work-related injuries and illnesses. 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 approved network physician on the initial visit.
 - ✓ Follow the approved network physician's instructions for any additional specialist treatment, if needed.
 - ✓ **Ensure all medical treatment is handled only through the approved network physician.**
 - ✓ Direct all questions about level of care to the approved network physician, who is the focal point for medical treatment.
 - ✓ Follow your state's established procedures to resolve 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 Workers' Compensation Law, my compensation benefits could be reduced for any injury that occurs because of failure to follow established safety procedures.

Employee

Date

Witness Signature

Date

Original to Personnel File / Copy to Employee