

New employee designated provider notification letter

Organization name: _____

To: All employees

From: _____

Date: _____

Subject: Designated medical providers for work-related injuries and illnesses

All employees must obtain treatment of work-related injuries and illnesses from one of the following medical providers:

1. Name: _____
 Address: _____
 City, state, zip: _____
 Phone: _____

2. Name: _____
 Address: _____
 City, state, zip: _____
 Phone: _____

3. Name: _____
 Address: _____
 City, state, zip: _____
 Phone: _____

4. Name: _____
 Address: _____
 City, state, zip: _____
 Phone: _____

In the event of a life- or limb-threatening emergency, the injured employee will be sent to the nearest emergency medical facility. One of the medical providers designated above must provide all follow-up care.

If an unauthorized medical provider treats an employee, the employee will be responsible for payment for said treatment.

I have read and am fully aware of the organization’s policy regarding medical treatment for work-related injuries and illnesses. I further understand that I must immediately report any work-related injury to my supervisor.

All employees must sign below, acknowledging this policy.

Employee name: _____

Employee signature: _____ Date: _____

Please review and customize this sample document to reflect your organization’s expectations. This is to be used as a supplement to and not in lieu of OSHA safety regulations and policies. Pinnacol Assurance assumes no responsibility for management or control of customer safety activities.