Revised 9/2014

WORKERS' COMPENSATION
PREFERRED PROVIDER PANEL CONSENT FORM
(PLEASE COMPLETE AFTER AN ACCIDENT)

I have **REVIEWED** the panel of physicians provided to me by my employer and **SELECTED** the medical provider listed below to receive medical treatment for my work-related injury.

I understand that if I fail to use one of the recommended medical providers, except in a medical emergency, I shall be liable for the cost of the medical care provided for in Section 65.1-89 of the Virginia Worker's Compensation Law.

When calling the provider for an appointment, inform them that the treatment is for a work-related injury and that the claims administrator is Sedgwick CMS, Inc.

PHYSICIAN _____

ADDRESS _____

_____ PHONE _____

EMPLOYEE NAME _____ SOCIAL SECURITY # XXX-XX- _ _ _ _

SIGNATURE _____ DATE _____

I have received and read the Winchester Public Schools Insurance policy EIA that contains information relating to Workers' Compensation (attached).

The first seven (7) days missed due to a workers' compensation injury can be taken as paid or unpaid leave. Paid leave is deducted from an employee's sick leave. Please indicate below your choice of paid or unpaid leave for first 7 days.

□ PAID (deducted from sick leave accrual)
□ UNPAID (leave without pay)

Employees who miss more than a total of seven (7) work days due to a workers' compensation injury are eligible for payment under the Workers' Compensation Insurance in the amount of 66 2/3% of their regular salary.

THIS FORM MUST ACCOMPANY THE EMPLOYER'S FIRST REPORT OF ACCIDENT.