PANEL ACKNOWLEDGEMENT FORM (PA ONLY)
NOTICE TO ALL EMPLOYEES TRAINING CONFIRMATION

PLEASE READ CAREFULLY
The information below describes your duties if you are injured at work.

IN CASE OF WORK-RELATED INJURY OR DISEASE

1. The employee has the duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for ninety (90) days from the date of the first visit to a designated provider.
2. The employee has the right to have all reasonable medical/surgical services and supplies, orthopedic appliances, and prostheses including required training in their use, related to the injury, paid for by the employer.
3. The employee has the right, during the ninety (90) day period to switch from one health care provider on the list to another provider on the list, and that all of the treatment shall be paid for by the employer.
4. The employee has the right to seek treatment from a referral provider if the employee is referred to him by a designated provider and the employer shall pay for the treatment rendered by the referral provider.
5. The employee has the right to seek emergency medical treatment from any provider but that subsequent, non-emergency treatment shall be by a designated provider for the remainder of the ninety (90) day period.
6. The employee has the right to seek treatment or medical consultation from a non-designated provider during the ninety (90) day period, but that these services shall be at the employee's expense for the applicable ninety (90) day period.
7. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to be followed provided that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care provides so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice.
8. The employee has the right to seek treatment from any health care provider after the ninety (90) day period has ended, and that treatment shall be paid for by the employer if it is reasonable and necessary. After ninety (90) days from the date of the first treatment, the employee shall have the duty to notify the employer of treatment by a non-designated provider within five (5) days of the first visit to the provider. The employer shall not be required to pay for treatment or services rendered by a non-designated provider prior to receiving this notification, if such services are determined, through utilization review, to have been unreasonable or unnecessary.
9. Written notice to an employee of the employer's/employee's rights and duties will be provided at time of training/hire and immediately after the injury or as soon thereafter as possible under the circumstances of the injury.
10. An employee may not refuse to sign an acknowledgement in order to avoid any duties specified in this notice.

I acknowledge that my employer has developed a list of at least six (6) panel providers. I understand that following a work-related injury or illness, I am required to visit one of the physicians or health care providers designated by my employer for the initial 90 days of treatment (Day 1 begins on the day of my first medical appointment). I understand that if I do not comply with this requirement, my employer will not be required to pay for any medical services I receive during this period. I also understand that after 90 days, I can treat with any other physician or provider of my choosing, provided I notify my employer within five (5) days of my first visit. If I fail to do so, my employer may be relieved from paying for these services if they are deemed to be unreasonable or unnecessary. My employer has informed me in writing of my rights and duties pertaining to the Pennsylvania Workers' Compensation Act. My signature below acknowledges that I have been so informed and that I understand my rights and duties.

Employee's Signature: ______________________________ Date: ____________________

Witness's Signature: ______________________________