

**Georgia Department of Behavioral Health
and Developmental Disabilities**

ACKNOWLEDGMENT OF WORKERS' COMPENSATION TREATMENT

My signature below indicates that I have been advised that as an employee of the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) I am covered by the Georgia Workers' Compensation Law. I have been informed that I am to immediately report all on-the-job injuries ***regardless of the extent of the injuries*** to my supervisor, HR/Personnel Representative or other authorized official. I realize that a delay in notification can result in denial of payment for any medical services rendered.

I understand that if I am injured while on the job and emergency treatment ***IS*** necessary, I will receive emergency treatment as soon as possible. All follow up care, however, must be provided by a Workers' Compensation physician listed on the **OFFICIAL NOTICE** which is posted in my work area.

I further understand that if emergency treatment is ***NOT*** necessary, I must receive treatment from a Workers' Compensation physician listed on the **OFFICIAL NOTICE**. If I obtain non-emergency medical treatment from a physician not on the **OFFICIAL NOTICE**, I will be responsible for any medical expenses.

I have been advised that if I am dissatisfied with the physician selected, I may make one change without permission to a second physician on the **OFFICIAL NOTICE**. Any further changes of physicians will require the permission of the Human Resources Manger or the State Board of Workers' Compensation.

If I have questions regarding the above, I should discuss them with my supervisor or other authorized official.

Signature of Employee

Date

Signature of HR/Personnel Representative/Supervisor/
Other Authorized Official

Date

***For additional information, please review DBHDD Human Resource Policy
#1701 - Workers' Compensation and Special Injury Return-To-Work Program***