Employee Acknowledgement Form

Employee Name _____ Employer _____

Date Hired _____

Employer:

1. Give the DWC Time of Hire Pamphlet to new employees when they are hired or by the end of their first pay period.
2. A copy of the Predesignation Form (DWC-9783) is attached to the pamphlet. An employee can use it to choose in advance to have their personal doctor treat work injuries.
3. Have the new employee complete and sign Section One below. Save a copy in their employee file.
4. When you learn a work-related injury has happened, you must give the injured worker a copy of the Employee Medical Provider Network Notice. Then, have the employee sign Section Two of this form. Send a copy of the signed form to Omaha National.
5. Please contact us at 844-761-8400 if you have any questions. Additional copies of the pamphlet and forms are on our website at omahanational.com.

Employee:

1. This form confirms your employer gave you documents about workers compensation.
2. You can use the Predesignation Form to choose to have your personal doctor treat you if you get hurt at work. To do this, you must:
    a. Give your employer written notice that you want your personal doctor to treat you for work injuries. The notice must be provided before an injury occurs and needs to contain the doctor's name and address;
    b. Have healthcare coverage (for injuries or illnesses not related to work) in a plan, policy, or fund; and
3. Get your personal doctor to agree to treat you for any work injuries. The Employee MPN Notice contains information about the Omaha National Medical Provider Network. It also has information on how to get medical care for your work injury.

Section One: Confirmation of DWC Time of Hire Pamphlet and Predesignation Form

I confirm that my employer gave me copies of the following documents:

☐ DWC Time of Hire Pamphlet

☐ Form DWC-9783 - Notice of Predesignation of Personal Physician (attached to the DWC Time of Hire Pamphlet)

☐ I understand it is my duty to tell my employer I have a work injury as soon as the injury happens.

Signature _____

Printed Name _____ Date _____

Section Two: Confirmation of Employee Medical Provider Network Notice

I confirm that my employer gave me a copy of the Employee Medical Provider Network (MPN) Notice. I understand that I must treat with a provider from the MPN unless I elected to be treated by my personal doctor.

I have read this form. I fully understand its entire contents. I have asked questions about anything that was not clear to me. I am satisfied with the answers I have received. I understand I have a right to ask for a copy of this form.

Signature _____

Printed Name _____ Date _____