Potomac Conference
CORPORATION OF SEVENTH-DAY ADVENTISTS®

WORK INJURY ACKNOWLEDGMENT

Workers' Compensation provides benefits to employees who sustain a work-related injury/illness. The Potomac Conference Corporation carries Workers' Compensation Insurance coverage through Church Mutual Insurance Company.

If I am injured at work I understand that the following procedure is to be observed:

- For life threatening emergencies, someone should call 911 immediately. Otherwise, if you are injured on the job, you must report it to your supervisor immediately – even if you do not feel that medical attention is necessary. The supervisor is to report the injury to Potomac Conference Human Resources within 24 hours so a claim can be filed with the worker's compensation carrier.
- You will be given a form to complete that will provide details of your injury to Human Resources.
- Seek urgent/emergent medical treatment as needed. Follow-up treatment may need to be coordinated with the workers' compensation adjuster assigned to your claim.
- Human Resources will file a claim with the insurance carrier once all required information is received from the employee and supervisor. As soon as a claim number is assigned, Human Resources will provide the employee/supervisor with billing information. It is your responsibility to provide this billing information to any medical providers that treated you for your work-related injury.

Please keep in mind that filing a claim does not ensure automatic acceptance by our insurance carrier. They must investigate each claim individually and make a determination based on the information available. If your claim is not compensable, you may be responsible for any bills that are incurred.

Under certain circumstances a work-related injury may be considered a serious health condition under the Family and Medical Leave Act (FMLA) and that you may be entitled to medical leave. For more information about FMLA, please refer to the Potomac Conference Working Policies or contact Human Resources.

By signing below I acknowledge that I have read the above statement regarding worker's compensation and that I understand it.

_____ _____
Employee Name Date

_____
Signature