Statement of Understanding for Workers' Compensation Injuries

1. I understand my rights under the Workers' Compensation Act of Georgia are summarized in the Bill of Rights for the Injured Worker that is posted in my work area.

2. I understand that I must report any on-the-job injury within 24 hours of that injury or as soon as possible to my employer. My supervisor will notify Cobb County Human Resources of my injury.

3. I understand that if my injury requires medical attention, I must choose a medical provider from the Panel of Physicians posted in my work area and/or on the Cobb Web.

4. I understand that Cobb County will pay for treatment of my on-the-job injury by the authorized medical providers listed on the Panel of Physicians or to medical providers I may be referred to by the authorized medical provider. Medical care for my on-the-job injury from unauthorized medical providers will be paid for at my own expense.

5. I understand that for injuries that require emergency treatment or that occur after normal business hours, I may seek treatment for my on-the-job injury from any medical provider, but once the emergency has been resolved I will seek treatment from my choice of medical provider from the county's approved Panel of Physicians.

6. I understand that the medical treatment for my on-the-job injury must be approved by the county's administrators for Workers' Comp in Human Resources or the county's Workers' Compensation Third Party Administrator and that I will cooperate with the authorized provider's treatment for my injury.

7. I understand that I must notify my supervisor of any follow up appointments for my injuries as soon as possible to insure staff coverage.

8. I understand that it is my responsibility to inform my supervisor of any medications, treatment or limitations that would prevent me from performing my assigned duties.

9. I understand that I may be required provide my supervisor with documentation of any scheduled appointments for treatment, therapy or time lost from work for my injury.

10. I understand that under Cobb County's Return to Work policy, that I will be notified by telephone of restricted/light duty assignments within my department or within another department.

11. I understand that if I receive a payout for the claim from a third party insurer, Cobb County may require repayment of all or part of the funds paid out for my medical care and lost time wages for my on-the-job injury.

12. I understand any injuries that occur as a result of secondary employment with employers other than Cobb County, do not arise out of and are not within the scope and course of my employment with Cobb County and are not covered under Cobb County's Workers' Compensation policy.

Employee Name_____Date_____Department_____

Employee Signature_____Supervisor_____

Revised 10/11