VILLANOVA
UNIVERSITY

WORKERS' COMPENSATION
EMPLOYEE NOTIFICATION

I understand that the University is required to pay for all my reasonable and necessary medical services required as a result of a work-related injury. If I am involved in a work-related injury, I am to inform my department head or supervisor without delay. I understand that I am required to treat with a health care provider identified as a panel physician and a facility on the list posted by the University on employee bulletin boards, and on the Human Resources website. I further understand that this restriction does not apply to emergency treatment if I am faced with an immediate life-threatening medical emergency.

Furthermore, I understand that I am required to treat with a panel physician for the 90 day period from the date of first treatment, and that should I not do so, the University is then not responsible for paying for health care services that I receive from other sources during the initial 90 day period. During that 90 day period of treatment by the panel physician, should the panel physician recommend invasive surgery, I am entitled to seek a second opinion from a physician of my choice at the University expense. Should my physician's opinion differ from that of the panel physician, and I choose to follow my physician's opinion, the panel physician will treat me accordingly during the mandatory 90 day period.

I understand that I may seek treatment from a health care provider of my own choice after I have treated with a panel physician for the mandatory 90 day period. If I choose to do this, I understand that I must inform the Human Resources offices within 5 days of my first visit. If I do not inform the Human Resources office of my election to seek treatment from a health care provider of my choice within the 5 days following the first visit after the mandatory 90 day period of treatment by the panel physician, I understand the University is not responsible for payment for any services performed or ordered by this health care provider until I do inform the Human Resources office of my change to my own health care provider. I understand that, once I properly inform the Human Resources office that I am treating with a health care provider following my treatment by a panel physician, all reasonable and necessary health care services will be paid by the University if it is determined that they continue to be needed for treatment of a bona fide work-related injury.

I am further informed that the health insurance plans offered by the University for non-work-related medical needs will not pay for treatment which is a result of a work-related medical condition, either before, during, or after the 90 day time frame.

I acknowledge that I have been informed of these rights and duties and that I understand them.

_____	_____
Employee Name (please print)	Employee Signature
_____	_____
Employee Banner ID#	Date

Revised 01/13