ROLLINS
HUMAN RESOURCES

Workers' Compensation
Employee Acknowledgement Form

Rollins College has agreed to provide workers' compensation coverage for health care service for work-related injuries and illnesses.

1. With my signature, I acknowledge that I have access to the Rollins College "*Report of On-The-Job Injury Requirements*" policy (Policy 800.20) located on the Human Resources website outlining my rights and responsibilities. I understand that it is my responsibility to ask questions if I do not understand any portion of the policy and/or procedures.

2. I understand that for life threatening emergencies, someone should call 911 immediately. Otherwise, if I am injured on the job, I must report it to my supervisor immediately. The employee is to report the injury to Campus Safety and Human Resources so a claim can be filed with the College's workers' compensation insurance carrier.

3. I understand that for job-related injuries:

    - I must be treated through a physician(s), clinic(s) or facility assigned by College's workers' compensation insurance carrier, except for medical emergencies.
    - The College's workers' compensation insurance carrier will authorize all hospital admissions, surgeries, physician visits, and other necessary medical care in accordance with the Florida Worker's Compensation Act. If a service is not authorized it will not be covered under my employers worker's compensation policy.
    - As per Florida state statute 440.13(2)(f), an employee is entitled to a one time change in physician during the course of treatment for one date of accident.

4. I understand that my employer can provide light duty work in most cases. My treating physician(s) will coordinate my return to work as soon as possible. I understand that normal duties may be modified to accommodate my condition and that any such modifications will be consistent with any applicable legal requirements.

5. I understand that under certain circumstances my workers' compensation injury MAY be considered a serious health condition under the Family and Medical Leave Act and that I may be entitled to medical leave. For more information I should contact Human Resources.

6. I authorize the College's workers' compensation insurance carrier and their designee, officers, agents, or employers, to release medical information to each other as appropriate or a third party in connection with any proceeding that results from an accident or injury that I am involved in.

ACKNOWLEDGEMENT OF EMPLOYEE:

_____ _____

Employee Signature and Date **Witness Signature and Date**

_____ _____

R-Number **Printed or Typed Name**

_____

Printed or Typed Name

If the employee is under the age of 18, he or she must have his/her parent or legal guardians sign the form.

_____ _____

Parent/Legal Guardian Signature and Date **Printed or Typed Name**