


Form AR-N	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	
Ark. Code Ann. §§11-9-701, 508, 514 AWCC Rule 099.33 Revised: 1-1-2001 Updated: 8-1-2006		

EMPLOYEE'S NOTICE OF INJURY

EMPLOYEE INFORMATION (Please Print in Ink)

Employee's Last Name	First Name	M I	Social Security Number	Home Phone No.
Street Address or P.O. Box	City	State	Zip Code	
Child Support Obligation: <input type="checkbox"/> Current <input type="checkbox"/> Past Due Payable to:				

EMPLOYER INFORMATION (Please Print)

Employer's Name	Supervisor's Name
Employer's Street Address or P.O. Box	Employer's City
State	Zip Code

ACCIDENT INFORMATION (Please Print)

Place of Accident	Date of Accident	Time of Accident	Date /Time Employer Notified of Accident
What part of your body was injured? _____ _____ _____			
Briefly discuss the cause of injury: _____ _____ _____			


Name/address of witness(es): _____

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, written or oral, including, but not limited to, copies of medical records concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician- and psychotherapist-patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original. My signature below also indicates that I have been provided with my rights regarding change-of-physician. (See additional information on back side of form)

Date _____ Signature _____

Assistance with AWCC Form N is available from the AWCC Legal Advisor Division (1-800-250-2511 or 501-682-3930). Information is supplied by the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

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EMPLOYER'S NOTICE TO EMPLOYEE

NOTICE TO EMPLOYEE - Fill out this form to give to your employer immediately. Employer: Be sure the employee receives a copy of this form [Ark. Code Ann. § 11-9--514 (c)]

Ark. Code Ann. § 11-9-701. Notice of injury or death.

- (a)(1) Unless an injury either renders the employee physically or mentally unable to do so, or is made known to the employer immediately after it occurs, the employee shall report the injury to the employer on a form prescribed or approved by the Workers' Compensation Commission and to a person or at a place specified by the employer, and the employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's report of injury.
- (2) All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements.
- (3) The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.
- (b)(1) Failure to give the notice shall not bar any claim:
 - (A) If the employer had knowledge of the injury or death;
 - (B) If the employee had no knowledge that the condition or disease arose out of and in the course of the employment; or
 - (C) If the commission excuses the failure on the grounds that for some satisfactory reason the notice could not be given.
- (2) Objection to failure to give notice must be made at or before the first hearing on the claim.

CHOICE/CHANGE OF PHYSICIAN

Rights and responsibilities. Treatment or services furnished or prescribed by any physician other than the ones selected according to the provisions below, except emergency treatment, shall be at the claimant's/employee's expense.

Ark. Code Ann. § 11-9-508. Medical services and supplies.

"(e) . . . [T]he injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions."

1. Your employer shall have the right to select the initial primary care physician from among those associated with certified MCOs.
2. You may request a change-of-physician. You should initially request a change from the insurance carrier or employer. Within five business days of your initial request for a change-of-physician, the insurance carrier or employer should notify you of its decision to grant or deny the change-of-physician.
3. If your request for change of physician is denied you may send a petition to the Clerk of the Arkansas Workers' Compensation Commission for a one (1) time only change-of-physician.
4. **If your employer has contracted with a certified MCO**, you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must also either be associated with the certified MCO chosen by your employer or who is your regular treating physician. (Your "regular treating physician" is one who maintains your medical records and with whom you have a history of regular treatment before the onset of your compensable injury.) The health care provider to whom you change must agree to refer you to the certified MCO chosen by your employer for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by the MCO initially chosen by your employer.
5. **If your employer does not have a contract with a certified MCO**, you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must either be associated with any certified MCO or who is your regular treating physician. (See definition above.) The health care provider to whom you change must agree to refer you to a physician associated with any certified MCO for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by any certified MCO.

Back side / Two-sided form



Employee Incident Report Non-Tx

Instructions: 1st Employment employees shall report **ALL** work related injuries, illnesses, or “near misses” events (which could have caused an injury or illness) – no matter how minor. This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by employees as soon as possible and given to a 1st Employment Representative for further action. **You can complete this form in the language you feel most comfortable with.**

I'm reporting a work related: ___ Injury ___ Illness ___ Near Miss

Your Name: _____

Job Title: _____

Have you transferred jobs since starting work? ___ Yes ___ No If yes, Date of Transfer: _____

On-Site Supervisor: _____

Have you told your On-Site Supervisor about this injury/illness/near miss? ___ Yes ___ No

If yes, when did you notify him/her? Date and Time: _____ at _____

When did you notify 1st Employment? Date and Time: _____ at _____

Date of injury/near miss: _____ Time of injury/near miss: _____

Names of witnesses (if any): _____

Where, exactly, did it happen? _____

How would you describe the environment you were working in at the exact time of the accident? Be specific, and please describe noises, smells, equipment, people, etc.

What were you doing before the accident? Be specific.

How did the accident occur? How did you get hurt? Be specific.

What did you do after the accident?

What specific equipment, tools, products, etc. were you handling?

What could have been done to prevent this accident?

What part(s) of your body were injured? If a near miss, how could you, or someone else, have been hurt?

Did you see a doctor about this injury/illness? Yes No

If yes, did you get prior approval from 1st Employment? Yes No

Date of your doctor's visit: _____ Time: _____

Doctor's name: _____

Doctor's location: _____

Doctor's phone number: _____

Has this part of your body been injured before? Yes No

If yes, when and where? _____

Do you have other jobs, including side jobs? Yes No

If yes, what is your side job? _____

Do you have any hobbies? Yes No

If yes, what is/are your hobby/hobbies? _____

NOTE: Please provide a sketch of the area where the accident occurred with as much details as possible that will help us understand what happened. You can email or drop off the sketch in our office within the next 24 hours.

Employee Signature

Date



REFUSAL OF MEDICAL TREATMENT (NW414.v2)

I do hereby refuse medical treatment offered by my employer, 1st Employment, for the above stated injury. Should I decide that medical treatment is necessary in the future, I will contact 1st Employment prior to seeking such treatment.

Employee Signature

Date

1st Employment Representative

Date