State of New York
WORKERS' COMPENSATION BOARD

Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider

Injured Employee's Name	Injured Employee's Social Security No.	Date of Accident
Employer's Name and Address		

To the Injured Employee:

For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Workers' Compensation Board authorized and who is accepting workers' compensation patients.

While you may choose to utilize a network or provider which is recommended by your employer or its workers' compensation insurance carrier or to permit your employer to select a provider on your behalf, you may, at any time, change your health care provider without jeopardizing your workers' compensation claim for benefits.

Signature of Injured Employee	Date	Signature of Witness	Date

Please note: It is not necessary for you to sign this consent form if your employer is (i)participating in a certified preferred provider organization (PPO) under Article 10-A of theWorkers' Compensation Law, or (ii) participating in the alternative dispute resolution (ADR)pilot program under section 25(2-c) of the Workers' Compensation Law. In accordance withthese statutory programs, except in emergency situations, you must obtain at least initialtreatment for any workers' compensation injury or illness from the certified network(s) orproviders designated by your employer.

To the Employer:

The employer shall provide the above-named injured employee with a copy of this signed form and shall maintain the original form in the employer's records where it may be inspected by the Workers' Compensation Board at any time. This form shall not be submitted to the Workers' Compensation Board nor shall it be executed prior to the occurrence of this employee's work-related injury or illness.

The Workers' Compensation Board employs and serves people with disabilities without discrimination.

纽约州
劳工赔偿局

关于选择劳工赔偿局授权医疗服务提供者的权利的通知

受伤员工姓名	受伤员工社会安全号码	事故日期
雇主名称及地址		

致受伤员工：

为治疗您的工伤疾病，您可以选择由劳工赔偿局授权、且接收享受劳工赔偿权益的患者的任何内科医生、足科医生、按摩师或心理医生（由授权的内科医生转介）。

虽然您可以选择使用雇主或其劳工赔偿保险公司推荐的医疗网络或医疗服务提供者，或允许雇主代为选择医疗服务提供者，但您可以随时更换医疗服务提供者，而且不会影响您的劳工赔偿诉讼。

受伤员工签字	日期	证人签字	日期

请注意： 如果您的雇主 (i) 参加了《劳工赔偿法》第 10-A 条规定的认证优选医疗服务组织 (PPO)；或者 (ii) 参加了《劳工赔偿法》第 25(2-c) 节规定的替代性争议解决方案 (ADR) 试点计划，则您无需签署本同意书。根据这些法定方案，紧急情况下除外，对于具有劳工赔偿资格的任何伤/病，您必须至少在雇主指定的认证医疗服务网络或提供者处接受初期治疗。

致雇主：

雇主须向上述受伤员工提供经签署的本同意书的副本，并留下原件存档，劳工赔偿局有权随时检查。本同意书不得在员工受工伤或患病前签署，无需提交给劳工赔偿局。

劳工赔偿局对残障人士采无差别雇用和服务政策。