Risk Management JPA
Fringe Benefits Consortium

SAN DIEGO COUNTY AND IMPERIAL COUNTY SCHOOLS

This is to acknowledge receipt of information regarding California Workers' Compensation laws and rights in addition to notice regarding the Medical Provider Network that my employer utilizes.

I HAVE READ THE ATTACHED INFORMATION AND UNDERSTAND MY RIGHTS AND BENEFITS UNDER THE WORKERS' COMPENSATION PROGRAM. I AGREE TO REPORT ALL WORK RELATED INJURIES AND ILLNESSES TO MY SUPERVISOR/EMPLOYER IMMEDIATELY AFTER THEY OCCUR.

EMPLOYEE NAME______________________________ **DATE**________________
(PLEASE PRINT)

EMPLOYEE SIGNATURE____

DISTRICT____

6401 Linda Vista Road, #505 • San Diego, CA 92111-7399 • (858) 569-5320 • Fax (858) 279-6236