CEG
NDACo COUNTY EMPLOYERS GROUP
WORK SMART – WORK SAFE

DESIGNATED MEDICAL PROVIDER SELECTION FORM

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The designated medical providers for _____ County are:

City	Provider

I have been informed of my employer's designated medical provider provisions.

Signature of Employee	Employee Name (please print)	Date

I wish to add the following designated provider(s) to seek treatment from in the event of a work place injury or illness:

Provider's Name	Provider's Address	
City	State	Zip Code
Provider's Name	Provider's Address	
City	State	Zip Code
Provider's Name	Provider's Address	
City	State	Zip Code

Do not return this form to WSI. This form should be kept by the employer and a copy given to the employee for their records.

DMP selection should be reviewed annually.

WSI may not pay for medical treatment by another provider unless a designated provider refers you or you list the provider above. Emergency care is exempt from the designated medical provider requirement.

I have been informed of my employer's designated Drug–Free Workplace Program.

Signature of Employee	Employee Name (please print)	Date