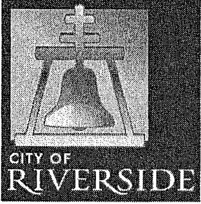

City of Riverside
Human Resources Department
Workers' Compensation Division

ACKNOWLEDGEMENT OF RECEIPT OF CITY OF RIVERSIDE WORKERS' COMPENSATION MEDICAL PROVIDER NETWORK INFORMATION

I acknowledge that I have received information regarding my employer's use of Medical Provider Network for Workers' Compensation claims. The information given to me includes:

1. **Medical Provider Network Official Notification**
2. **City of Riverside Medical Provider Network**
3. **Pre-Designation of Physician Form**

______________________________	________________
Employee/Volunteer's Name (Print)	Employee ID#
______________________________	________________
Employee/Volunteer's Signature	Today's Date