ALLIANCE INTERSTATE RISK SERVICE

Welcome to Alliance Interstate Risk!

We have been providing workers' compensation coverage to the transportation industry for more than 25 years. Our industry-leading, behavior-based Risk Management and Safety Services help you develop and manage a safer work environment. In addition, expert Claims Management focuses on driving down the severity, duration and total cost of claims. *The results are a proven safety culture and a more profitable business.*

In the enclosed folder, you will find information and forms for your coverage provided through Alliance Interstate Risk. These include:

— Quarterly Payroll Monitoring Guidelines
— Annual Audit Expectations
— How to File a Claim
— Post Job Offer Medical Questionnaire
— Company Driver Notification
— Owner-Operator Notification

to report a claim:
CCMSI (Claim TPA)
[e] ATA@CCMSI.com
[p] 844.858.8237

for questions regarding claims:
Suzy Baker (Claim Manager)
[e] SBaker@ATACompFund.com
[p] 334.425.4218

Risk Management Services

Contact your Risk Manager to take advantage of the many customized services provided to you as part of the Alliance Interstate Risk program:

— Loss Control inspections & safety meetings
— Mock FMCSA compliance audits
— Simulated OSHA compliance surveys
— OSHA Alliance Membership
— Free Safety posters, stickers, etc.
— Customized training videos

MaryAnn Brown, CDS, TRS | *Risk Manager*
[p] 470.449.3016
[e] MBrown@AllianceInterstateRisk.org

Patrick Monahan, CRIS | *Risk Manager*
[p] 615.587.4594
[e] PMonahan@AllianceInterstateRisk.org

Candy Woodruff, CDS, TRS, SSH | *Risk Manager*
[p] 334.315.7620
[e] CWoodruff@AllianceInterstateRisk.org

Victor Whatley, CSP, CDS, TRS | *Risk Manager*
[p] 251.622.1898
[e] VWhatley@AllianceInterstateRisk.org

Will Moses, TRS, CSS | *Risk Manager*
[p] 334.429.2293
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ALLIANCE INTERSTATE RISK SERVICE

Quarterly Payroll Monitoring

Each quarter, a reminder will be sent for copies of the previous quarter's 941 Federal Tax Return and State Unemployment Compensation tax return for all states in which your company files.

Alliance Interstate Risk Service uses this information, as well as records of other wages, in the ongoing underwriting review of your policy as the year progresses.

There are many reasons for this underwriting review:

—Payrolls are monitored and adjustments will be made to estimates in cases of growth or decline.

—Contractor wages are monitored for exposure-related concerns.

—Owner Operator/Lease Purchase/Subcontract Driver information and wages are monitored if applicable for exposure.

—All information is used to keep the policy(ies) as accurately estimated as possible to avoid large discrepancies with audit results.

While it is your company's responsibility to notify AIRS with any expected significant change in payrolls or operations, this process helps monitor for any change that may require further review.

This information can be submitted to our office via email (ServiceRequest@ATACompFund.org) or via fax (334.834.7931). We look forward to the opportunity to show you why the Alliance Interstate Risk program is a step above in not only resources and training, but in our service as well!

Annual Audit Information

Once a policy period has ended (typically January 1st), payroll audits will be performed for the expiring policy term. AIRS partners with skilled premium auditors from Sedgwick to perform these audits nationwide. Once your company has been assigned an auditor, you will be contacted to schedule the physical audit. Audits must be completed on-site at your location and signed by an officer of the company(ies).

Some of the items the auditor will be prepared to evaluate to complete the audit are as follows:

—All quarters of previous year's 941 Federal Tax Return and State Unemployment Compensation Tax Return (all applicable states)

—Previous year 1099 forms and Year-End 1096 form

—Year-End Payroll Summary (including overtime and per diem records)

—Owner Operator/Lease Purchase/Subcontract Driver information, including weeks worked and payments made

—Casual Labor/Contract Labor/Subcontractor Labor records, including certificates of insurance for their workers' compensation coverage, if applicable

A detailed list of required information will be provided at the time of audit scheduling.

Owner Operator/Contract Driver Audit Worksheet

**If your company has more owner operators than there is room to list on one sheet, please make additional copies.
If your company does not use owner operators, please write "NONE" on this form and sign.

EACH INDIVIDUAL DRIVER MUST BE LISTED OF SMALL FLEET OWNERS.

Insured ____

Owner Operator's Name	# of drivers	Age of Driver	Amount Paid during coverage period	# of weeks worked during coverage period

**Signature ____________________________________ Title ______________________

(must be signed by an officer of the company)

ALLIANCE INTERSTATE RISK
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Lease Purchase Operator/Contract Driver Audit Worksheet

**If your company has more lease purchase operators than there is room to list on one sheet, please make additional copies.
If your company does not use lease purchase operators, please write "NONE" on this form and sign.

Insured ____

Lease Purchase Operator's Name	Age of Driver	Amount Paid during coverage period	# of weeks worked during coverage period

**Signature ____________________________________ Title ______________________
(must be signed by an officer of the company)

AIR
ALLIANCE INTERSTATE RISK
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1099 or Cash Laborer Worksheet
(Other than Owner Operators / Lease Purchase Operators)

**If your company has more laborers than there is room to list on one sheet, please make additional copies. If your company does not use 1099 or cash paid laborers, please write "NONE" on this form and sign.

Insured _____

Laborer's Name	Laborer's Job Description	Wages Paid during coverage period	Laborer's WC Coverage? (Y/N) Provide COI

**Signature _____ Title _____

(must be signed by an officer of the company)

ALLIANCE INTERSTATE RISK SERVICE

How to Report a Claim

Complete the State First Report of Injury and submit:

By e-mail: ATA@CCMSI.com

This is our preferred method of receiving your first report of injury

By phone: (844) 858-8237

Press '1' to report a claim
(Available anytime- days, nights & weekends)

Press '2' to inquire about a claim
(Available 8:00am to 5:00pm EST)

After reporting the claim, a CCMSI adjuster will contact you within 24 hours.

Additional Instructions:

If you have any supporting documents (reports, bills, etc.) associated with a newly reported claim, please wait for the adjuster's contact information. Do not send these documents to the call center.

ALLIANCE INTERSTATE RISK SERVICE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTIVE HEALTH INFORMATION

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

(Street) (City/State/Zip)

Social Security #: _____ Telephone: ( ) -

Information to be Released – Covering the Periods of Heath Care

From (date): 1992 To (date): _____

From (date): _____ To (date): _____

Please check type of information to be released.

- ☐ Entire Medical Record
- ☐ History and Physical Exam
- ☐ Laboratory Test Results/Reports
- ☐ Operative Report
- ☐ Other (Specify)
- ☐ Pathology Report
- ☐ Consultation Reports
- ☐ X-Ray Reports
- ☐ Emergency Room Report
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ X-Ray Film/Images
- ☐ Itemized Bill

Purpose of Request

- ☐ Treatment or consultation
- ☐ Billing or claims payment
- ☐ At request of the patient
- ☐ Other (Specify)

Person Authorized to Receive Information

Name: **CCMSI** Address: **2 East Main Street, Ste 208; Danville IL 61832**

Drug and/or Alcohol Abuse, and/or Psychiatric and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing and/or other sensitive information, I agree to its release. Check One: ☐ Yes ☐ No Initials: _____

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agreed to its release. Check One: ☐ Yes ☐ No Initials: _____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer. Unless revoked, this authorization will expire on the following date of event 7 years from date of signature.

Re-Disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that any & all providers may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize any and all providers to use and disclose the protected heath information specified above.

A photocopy of this authorization shall have the same force and effect as the original.

Signature: _____ Date: _____

Verified by: _____

Doctor's Full Name _____

Hospital Name (if applicable) _____

Complete Address _____
(Number and Street or P.O. Box)

_____
(City, State and Zip)

ADDITIONAL INFORMATION

Doctor's Full Name _____

Hospital Name (if applicable) _____

Complete Address _____
(Number and Street or P.O. Box)

_____
(City, State and Zip)

WAGE STATEMENT

Re: _____ (CLAIMANT)

As Third-Party Administrator for the Alliance Interstate Risk program, CCMSI has received the above-referenced claim.

In order to process any indemnity benefits that may be due under the referenced claim, the following is requested:

1. Wage and Fringe Benefit information, excluding per diem and expense data.

2. Value of Employer-Paid Fringe Benefits. Form is not to be completed unless fringe benefits ARE NOT CONTINUED by the Employer during the claimant's disability.

Without this information, any indemnity benefits that may be due cannot be paid.

Completed forms should be emailed to your assigned adjuster.

Employer Responsibilities

- **Prompt Reporting of Losses**

  Every department manager and every supervisor must be trained to immediately report all claims to the employer's workers' compensation coordinator. If the employer does not have a workers' compensation coordinator, the supervisor or manager for the employer must immediately complete the First Report of Injury form and submit it to CCMSI.

  All claims must be reported to CCMSI as soon as possible, but in no event, shall the report be made later than five (5) days from the date the employer becomes aware of the injury. For members of the Certified Safety Program, claims must be reported within two (2) business days from the date the employer becomes aware of the injury.

- **Post-Accident Drug Testing**

  Post-Accident drug testing is a requirement of the Alliance Interstate Risk program. When your employee receives initial medical treatment, be sure to request a "Non-DOT" DOT drug test be administered immediately; unless otherwise specified by DOT regulations. Insist the Chain of Custody is followed – especially at hospitals.

- **Aggressive Claim Investigation**

  When a workers' compensation claim is reported, immediately begin to investigate the scene. This includes but is not limited to taking pictures (camera or phone); reviewing video; locating potential witnesses and obtaining statements; and preserving evidence i.e. vehicles and/or equipment associated with the accident (ladders, grinders, saws, etc…). This investigation will assist CCMSI with determining compensability of the claim and mitigating the duration of lost time from work and medical treatment.

- **Medical Treatment**

  If the injury is life threatening, then contact 911 immediately. If the injury is not life threatening, then take the injured employee to your designated medical facility. Be prepared and have this facility ready in the event of an injury. For any questions on medical facilities, please contact your CCMSI adjuster.

- **Early Return to Work/Availability of Alternative Work**

  Employers should provide temporary modified duty consistent with the recognized treating physician's written restrictions. This temporary modified duty places injured workers back in the work arena promoting recovery and preventing "disability syndrome". If you are unable to provide temporary modified duty, please request information for your adjuster regarding the ReEmployability modified duty program.

- **Litigation**

  Employers must notify CCMSI immediately of any legal correspondence you may receive and cooperate with any request made by the assigned defense attorney.

Our primary goal is to provide prompt and proper medical care for your injured employee with the best outcomes possible while at the same time positively impacting claim duration and costs.

POST JOB OFFER – MEDICAL QUESTIONNAIRE

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members.

In order to comply with this law, we are asking that you NOT provide any genetic information when responding to this request for medical information. 'Genetic Information', as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family members sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

DATE: _____ POSITION: _____

NAME: _____

A. DO YOU EVER HAVE:

Reactions to medicines YES ☐ NO ☐ EXPLAIN? _____

Reactions to oils YES ☐ NO ☐ EXPLAIN? _____

Reactions to chemicals YES ☐ NO ☐ EXPLAIN? _____

Skin rashes or eczema YES ☐ NO ☐ EXPLAIN? _____

B. HAVE YOU EVER HAD:

Asthma YES ☐ NO ☐ EXPLAIN? _____

Hay fever YES ☐ NO ☐ EXPLAIN? _____

Shortness of breath when walking YES ☐ NO ☐ EXPLAIN? _____

C. DO YOU HAVE OR EVER HAD:

Hernia YES ☐ NO ☐ EXPLAIN? _____

Diabetes YES ☐ NO ☐ EXPLAIN? _____

Knee Pain YES ☐ NO ☐ EXPLAIN? _____

D. EYES:

Do you use contacts or glasses YES ☐ NO ☐ EXPLAIN? _____

E. HAVE YOU EVER HAD:

High blood pressure YES ☐ NO ☐ EXPLAIN? _____

Heart trouble YES ☐ NO ☐ EXPLAIN? _____

Heart attack YES ☐ NO ☐ EXPLAIN? _____

Heart surgery YES ☐ NO ☐ EXPLAIN? _____

Fainting spells YES ☐ NO ☐ EXPLAIN? _____

Varicose veins YES ☐ NO ☐ EXPLAIN? _____

Swelling of ankles YES ☐ NO ☐ EXPLAIN? _____

F. HAVE YOU EVER HAD:

Seizures or convulsions YES ☐ NO ☐ EXPLAIN? _____

Epilepsy YES ☐ NO ☐ EXPLAIN? _____

Paralysis YES ☐ NO ☐ EXPLAIN? _____

Numbness in hands or feet YES ☐ NO ☐ EXPLAIN? _____

Double vision YES ☐ NO ☐ EXPLAIN? _____

Severe headaches YES ☐ NO ☐ EXPLAIN? _____

Migraine headaches YES ☐ NO ☐ EXPLAIN? _____

Dizzy Spells YES ☐ NO ☐ EXPLAIN? _____

G. HAVE YOU EVER HAD:

Neck injury or pain YES ☐ NO ☐ EXPLAIN? _____

Back injury or pain YES ☐ NO ☐ EXPLAIN? _____

Neck surgery YES ☐ NO ☐ EXPLAIN? _____

Back surgery YES ☐ NO ☐ EXPLAIN? _____

Knee surgery YES ☐ NO ☐ EXPLAIN? _____

Shoulder injury or pain YES ☐ NO ☐ EXPLAIN? _____

Shoulder surgery YES ☐ NO ☐ EXPLAIN? _____

Rheumatism or arthritis YES ☐ NO ☐ EXPLAIN? _____

Fracture/break or bone YES ☐ NO ☐ EXPLAIN? _____

H. Are you taking medicine Regularly? YES ☐ NO ☐

AMOUNT AND TYPE: _____

I. Are you currently using illegal drugs or harmful substance? YES ☐ NO ☐

AMOUNT AND TYPE: _____

_____ INT

I acknowledge that the Alliance Interstate Risk program mandates that if I refuse to submit to or cooperate with a blood or urine test after an accident, I shall forfeit Workers' Compensation benefits.

_____ INT

I acknowledge that misrepresentation as to preexisting physical or mental conditions may void my Workers' Compensation benefits.

Signature of Applicant: _____ Date: _____

Company Representative: _____

The Undersigned understands that the Alliance Interstate Risk program requires the execution of a post job offer medical questionnaire. The undersigned agrees to complete said questionnaire truthfully and agrees to allow the disclosure of it to the Company and/or Alliance Interstate Risk Service to determine whether the Undersigned is fit for duty. For DOT covered employees, under 49 CFR 191.11, the employer makes the final driver fitness-for-duty determination.

ALLIANCE INTERSTATE RISK SERVICE

INDEPENDENT CONTRACTORS / OWNER OPERATORS / SUB-CONTRACT DRIVERS / LEASE PURCHASE OWNER OPERATORS' AGREEMENT

_____ (the "Company") is a member of Alliance Interstate Risk (AIR) Program purchasing its own separate workers' compensation policy for its W-2 employees. Because of this membership participation, you, as an independent contractor, owner operator, sub-contract driver or lease purchase owner operator, are eligible to purchase your own workers' compensation coverage through the policy titled "OWNER OPERATORS / SUB-CONTRACT DRIVERS UNDER LEASE TO _____" as provided to you by the AIR Program. This policy provides workers' compensation benefits if you are injured while performing the duties of your occupation while under dispatch to the Company. Independent Contractors, Owner Operators, Sub-contract Drivers, and Lease Purchase Owner Operators are eligible for participation in the AIR Program to purchase your own workers' compensation coverage. You are not eligible to participate in the AIR Program, nor to purchase your own workers' compensation coverage if you are an employee or are a company driver for any company that is required by state law to provide workers' compensation coverage to its employees or company drivers. In order to participate, you must agree to the following terms and conditions as set out below:

1. You, the undersigned Independent Contractor, Owner Operator, Sub Contract Driver, or Lease Purchase Owner Operator (hereinafter the "Undersigned"), acknowledge and agree that the following terms and conditions shall govern the administration of any claim for workers' compensation benefits arising out of an injury sustained in the course of performing your work, which said benefits are payable through your coverage through the "OWNER OPERATORS / SUB-CONTRACT DRIVERS UNDER LEASE TO _____" policy provided by the AIR Program. You, the Undersigned, agree that:

   - **The Undersigned is not an employee or company driver of a company required by state law to provide workers' compensation coverage to its employees or company drivers.**
   - **The Undersigned has chosen to obtain his or her own workers' compensation coverage as a result of the membership of the Company in the AIR Program purchasing its own separate workers' compensation policy for its W-2 employees.**
   - **The amount the Undersigned will be charged as premium under the policy will be calculated using a wage base of $ 675 per week ($35,100 per year). In the event of a compensable on-the-job injury, indemnity (money) benefits will be calculated using the same wage base of $ 675 per week ($35,100 per year).**

   Wage base as described above acknowledged and agreed: _____ (Undersigned initials)

2. You, the Undersigned, acknowledge and agree that although the Undersigned is an independent contractor, owner operator, sub-contractor or lease purchase owner operator, and not an employee of the Company, the Undersigned's workers' compensation coverage, compensability determinations, and benefits payable, if any, will be determined pursuant to the state claim handling jurisdiction. The Undersigned acknowledges and agrees that the Undersigned is not an employee of the Company.

   You, the Undersigned, acknowledge and agree that all claims for workers' compensation benefits are subject to immediate post-accident drug testing. The undersigned acknowledges and agrees that this document shall satisfy any written notice requirement of the state claim handling jurisdiction concerning post-accident drug testing and any action taken thereon.

"A positive drug test conducted and evaluated pursuant to standards adopted for drug testing by the U.S. Department of Transportation in 49 C.F.R. Part 40 shall be a conclusive presumption of impairment resulting from the use of illegal drugs. No compensation shall be allowed if [You refuse] to submit to or cooperate with a blood or urine test as set forth above following the accident, after having been warned in writing by [The AIR Program] that such refusal would forfeit [Your] right to recover benefits under this chapter."

3. You, the Undersigned, acknowledge and understand any claim for workers' compensation benefits may be disqualified for (1) willful misconduct; (2) intentional self-inflicted injury; (3) intoxication or illegal drug usage or; (4) willful failure or refusal to use a safety device depending on the state claim handling jurisdiction.

4. You, the Undersigned, acknowledge that any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining compensation, as amended, for himself or herself, or any other person could be guilty of a crime in the state claim handling jurisdiction which could be punishable by imprisonment, fines, or denial of claim benefits.

5. You, the Undersigned, acknowledge and agree that as a condition of eligibility, you will make no misrepresentations as to existing or prior physical condition, mental condition and/or ability to fulfill the duties of the job. **"MISREPRESENTATIONS AS TO PREEXISTING PHYSICAL OR MENTAL CONDITIONS MAY VOID YOUR WORKERS' COMPENSATION BENEFITS."** Any injury sustained during the course of [Your work], no matter how minor or trivial, **MUST IMMEDIATELY BE REPORTED TO YOUR DESIGNATED COMPANY CONTACT OR OTHER MANAGEMENT PERSONNEL.**

6. You, the Undersigned, acknowledge and agree that this document does not constitute, and shall not serve as, a contract for employment with the Company listed herein.

7. You, the Undersigned, acknowledge and agree that the clauses and paragraphs contained in this agreement are intended to be read and construed independently of each other, and of any separate lease agreement entered into between the Company and you. If any term, covenant, condition or provision of this agreement is determined to be invalid, void, or unenforceable, by a circuit court within the state of claim jurisdiction, the remaining provisions shall not be affected, and shall remain in full force and effect as between the Company and you.

8. You, the Undersigned, acknowledge receipt of the fully executed copy of this Form.

Independent Contractor / Owner-Operator Sub-Contract Driver / Lease Purchase Owner Operator (Signature)	Company Representative (Signature)
Print Name	Print Name
Date Signed	Title
	Date Signed

ALLIANCE INTERSTATE RISK SERVICE

WORKERS' COMPENSATION NOTIFICATION

The undersigned applicant and/or employee (hereinafter "undersigned") acknowledges and agrees that the following terms and conditions shall govern any employment relationship for the purposes of workers' compensation benefits by or on behalf of _____ through
(Employer Company Name)
the Alliance Interstate Risk (AIR) Program.

1. The employer listed above is a participating member of the AIR Program for the purposes of payment of workers' compensation benefits.

2. It is acknowledged and agreed by the undersigned that: (1) the applied for and/or proposed employment position will require the employee to regularly travel in the state of hire as well as in one or more other states; (2) employment will be principally localized in the state of hire for the purposes of payment of any workers' compensation benefits; (3) the undersigned will accept the state of hire workers' compensation benefits paid in accordance with the Workers' Compensation Act of the state of hire, to the exclusion of any other state's jurisdiction or workers' compensation law; and (4) jurisdiction of any on-the-job injury and workers' compensation claim shall be in the state courts of the state of hire.

3. All claims for workers' compensation benefits are subject to medically approved "early return to work" programs, including modified driving and/or job assignments in the corporate offices, assigned work with approved charities or non-profit organizations through a structured return to work program or as otherwise directed.

4. All claims for workers' compensation benefits are subject to immediate post-accident drug testing. The undersigned acknowledges and agrees that this document shall satisfy any written notice requirement concerning post-accident drug testing and any action taken thereon. **"A positive drug test conducted and evaluated pursuant to standards adopted for drug testing by the U.S. Department of Transportation in 49 C.F.R. Part 40 shall be a conclusive presumption of impairment resulting from the use of illegal drugs. No compensation shall be allowed if the employee refuses to submit to or cooperate with a blood or urine test as set forth above following the accident, after having been warned in writing by the employer that such refusal would forfeit the employee's right to recover benefits under this chapter."**

5. You, the undersigned, acknowledge and understand any claim for workers' compensation benefits may be disqualified for (1) willful misconduct; (2) intentional self-inflicted injury; (3) intoxication or illegal drug usage or; (4) willful failure or refusal to use a safety device depending on the claim jurisdiction.

6. You, the undersigned, acknowledge that any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining compensation, as amended, for himself or herself, or any other person could be guilty of a crime in the state of hire which could be punishable by imprisonment, fines, or denial of claim benefits.

7. You, the undersigned, acknowledge and agree that as a condition of eligibility, you will make no misrepresentations as to pre-existing or prior physical condition, mental condition and/or ability to fulfill the duties of the job. Any injury sustained during the course of [Your work], no matter how

minor or trivial, **MUST IMMEDIATELY BE REPORTED TO YOUR DESIGNATED COMPANY CONTACT OR OTHER MANAGEMENT PERSONNEL.**

8. The undersigned acknowledges and agrees that this document does not constitute, and shall not serve as, a contract for employment with the employer listed herein or any others. The undersigned understands and agrees that any employment relationship to be formed between the employer and the undersigned, or which currently exists, is and shall be "at will" subject to the laws of the state of hire.

9. The undersigned acknowledges receipt of the fully executed copy of this form.

Employee/Applicant Signature	Employer/Representative Signature
Employee/Applicant Name (Print)	Employer/Representative Name (Print)
Date Signed	Position/Title
	Date Signed

ALL EMPLOYEES ARE REQUIRED TO SIGN: If a new employee or conditional hire, a signature is required at time of the conditional offer of employment and/or the time of hire. If an existing employee, sign and return to Human Resources or your supervisor within ten (10) business day of receipt of a certified letter, this workers' compensation notification will be made a part of the employee's personnel file.