California Medical Provider Network (MPN)
Acknowledgement Form

I have received the information that tells me how to obtain medical care within the

____.
(Name of MPN)

I understand that if medical care is needed for a work-related injury I must be treated by an approved doctor to qualify for benefits. Approved doctors are either a physician in the Medical Provider Network or my predesignated personal physician.

In case of an emergency, I understand that I should call 911 or go to the closest emergency room.

______________________________________ ___________________________
(Signature) (Date)

____
(Printed Name)

I live at ____
(Street Address)

____

____
(City) (State) (Zip Code)

Name of Employer ___________________________________