ACKNOWLEDGEMENT OF RECEIPT OF MPN INFORMATION

| Employee's Signature | Today's Date |
|--|--------------|
| | |
| | |
| Employee's Name (please print) | |
| | |
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| | |
| l acknowledge that I have received information regarding my employer's use of a Medical Provider Network for Workers' Compensation claims. | |

Employee: Please return this form to your employer

Employer: Please place in Employee's Personnel file