Form AR-N	ARKANSAS WORKERS' COMPENSATION COMMISSION	N
Ark. Code Ann. §§11-9-701, 508, 514 AWCC Rule 099.33 Revised: 1-1-2001 Updated: 8-1-2006	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

EMPLOYEE'S NOTICE OF INJURY

EMPLOYEE INFORMATION (Please Print in Ink)

Employee's Last Name	First Name	M I	Social Security Number	Home Phone No.
Street Address or P.O. Box	City	State	Zip Code	

Child Support Obligation: ❑ Current ❑ Past Due Payable to:

EMPLOYER INFORMATION (Please Print)

Employer's Name	Supervisor's Name		
Employer's Street Address or P.O. Box	Employer's City	State	Zip Code

ACCIDENT INFORMATION (Please Print)

Place of Accident	Date of Accident	Time of Accident	Date /Time Employer Notified of Accident

What part of your body was injured? _____

Briefly discuss the cause of injury: _____

Name/address of witness(es): _____

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, written or oral, including, but not limited to, copies of medical records concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician- and psychotherapist-patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original. My signature below also indicates that I have been provided with my rights regarding change-of-physician. (See additional information on back side of form)

Date _____ Signature _____

Assistance with AWCC Form N is available from the AWCC Legal Advisor Division (1-800-250-2511 or 501-682-3930). Information is supplied by the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

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EMPLOYER'S NOTICE TO EMPLOYEE

NOTICE TO EMPLOYEE - Fill out this form to give to your employer immediately. Employer: Be sure the employee receives a copy of this form [Ark. Code Ann. § 11-9--514 (c)]

Ark. Code Ann. § 11-9-701. Notice of injury or death.

(a)(1) Unless an injury either renders the employee physically or mentally unable to do so, or is made known to the employer immediately after it occurs, the employee shall report the injury to the employer on a form prescribed or approved by the Workers' Compensation Commission and to a person or at a place specified by the employer, and the employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's report of injury.

(2) All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements.

(3) The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

(b)(1) Failure to give the notice shall not bar any claim:
(A) If the employer had knowledge of the injury or death;
(B) If the employee had no knowledge that the condition or disease arose out of and in the course of the employment; or
(C) If the commission excuses the failure on the grounds that for some satisfactory reason the notice could not be given.

(2) Objection to failure to give notice must be made at or before the first hearing on the claim.

CHOICE/CHANGE OF PHYSICIAN

Rights and responsibilities. Treatment or services furnished or prescribed by any physician other than the ones selected according to the provisions below, except emergency treatment, shall be at the claimant's/employee's expense.

Ark. Code Ann. § 11-9-508. Medical services and supplies.

"(e). . . [T]he injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions."

1. Your employer shall have the right to select the initial primary care physician from among those associated with certified MCOs.

2. You may request a change-of-physician. You should initially request a change from the insurance carrier or employer. Within five business days of your initial request for a change-of-physician, the insurance carrier or employer should notify you of its decision to grant or deny the change-of-physician.

3. If your request for change of physician is denied you may send a petition to the Clerk of the Arkansas Workers' Compensation Commission for a one (1) time only change-of-physician.

4. **If your employer has contracted with a certified MCO,** you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must also either be associated with the certified MCO chosen by your employer or who is your regular treating physician. (Your "regular treating physician" is one who maintains your medical records and with whom you have a history of regular treatment before the onset of your compensable injury.) The health care provider to whom you change must agree to refer you to the certified MCO chosen by your employer for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by the MCO initially chosen by your employer.

5. **If your employer does not have a contract with a certified MCO,** you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must either be associated with any certified MCO or who is your regular treating physician. (See definition above.) The health care provider to whom you change must agree to refer you to a physician associated with any certified MCO for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by any certified MCO.

Back side / Two-sided form

v. 10/10/2011

FORM PECD 1
EMPLOYEE'S REPORT OF ACCIDENT

PUBLIC EMPLOYEE CLAIMS DIVISION
Arkansas Insurance Department
1200 West Third, Little Rock, Arkansas 72201-1904
Telephone 501-371-2700 Facsimile 501-371-2733

TO BE COMPLETED BY EMPLOYEE:

Name: _____ Tel #_____

Address: _____

Birth Date: _____ Marital Status: _____ Spouse's Name: _____

Dependents Names and Ages: _____

Education (Circle highest level completed) 1 2 3 4 5 6 7 8 9 10 11 12 GED College 1 2 3 4 5+

Present Employer: _____

Job Title: _____ Length of Employment: _____

If less than 5 years, list employers of last 5 years: _____

_____

Date of Accident: _____ Time: _____ Place: _____

Describe activity of employment engaged in at time of injury: _____

_____

Describe how injury occurred: _____

_____

_____

To whom did you report the injury: _____

When: _____ Supervisor's Name: _____

Nature and location of injury (describe part of body): _____

Doctor's Name: _____ Family Doctor's Name: _____

Who Selected Doctor? _____ Are you still under doctor's treatment?_____

Date of First Visit? _____ First Day Unable To Work? _____

Have you ever collected compensation for a prior injury? _____

If yes, give details: _____

_____

Have you ever received medical or chiropractic treatment to this part of the body before (either as a workers' compensation or a non-workers' compensation injury)? ____ Yes ____ No. If yes, give details including date: _____

Do you have child support obligations?___ Yes ____ No (Child support obligation questions are required by Ark. Law)

If yes, are the obligations current or past due? _____ Current or _____ Past Due

To whom are the child support obligations payable? _____

Are you enrolled in the Medicare Program? ____ Yes ____ No (Medicare question is required by federal law.)

Have you applied for Social Security Disability? __ Yes __ No Date Applied for Social Security _____

If you applied for social security disability, was your claim approved or denied? ___ Approved ___ Denied

Signed: _____ Date: _____