

# UND DESIGNATED MEDICAL PROVIDER FORM

ALL EMPLOYEES - This form must be completed and signed by all employees to document your understanding of UND's Designated Medical Provider (DMP) Policy. If you wish to designate a medical provider other than those designated by UND, please provide such information in the space provided. DMP forms must be on file prior to receiving treatment. Failure to comply with these requirements could jeopardize the compensability of resulting workers compensations claims.

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UND participates in the Workforce Safety and Insurance (WSI) Risk Management Program. This allows the Risk Management Workers Compensations Program (RMWCP) to designate health care providers to treat your workplace injuries and illnesses.

WSI may not pay for medical treatment to another provider unless you are either referred to this provider by the Designated Medical Provider, or unless you designated in writing prior to the injury that you wanted to be treated by a different medical provider. Emergency care is exempt from this requirement.

**UND employees injured on the job must seek medical treatment as follows:**

**Primary DMP: Altru Occupational Health** - 780-1546 (Phone) 1300 Columbia Rd. So., Altru Health Institute Bldg. *Can be utilized for all employees for any injuries, including but not limited to those of a serious nature.*

**OR**

**Alternate DMP: UND Student Health Services** - 777-2605 (Phone) PO Box 9038, 2891 2<sup>nd</sup> Ave No., McCannel Hall. *For minor injuries only, such as cuts/scrapes likely requiring only ONE visit..*

**Employees intending to see a medical provider other than the University's DMP's must designate this in writing before utilizing that provider's services.** This is accomplished by filling in the blanks below. You are not required to designate an additional DMP, but **you must sign and return this form** regardless.

I wish to designate the following provider as a designated provider to seek treatment from in the event of a workplace injury or illness (e.g. Dr. Smith/The Back Clinic - Chiropractic Services):

\_\_\_\_\_  
Physician/Clinic

\_\_\_\_\_  
Situation

\_\_\_\_\_  
Physician/Clinic

\_\_\_\_\_  
Situation

\_\_\_\_\_  
Physician/Clinic

\_\_\_\_\_  
Situation

All designations take effect upon submission to the Safety & Environmental Health. This designation does not cover any prior work-related injuries.

This statement remains in effect until another form is submitted by the employee.

Employee Name (**Please Print**): \_\_\_\_\_ Social Security # \_\_\_\_\_ EMPLID \_\_\_\_\_

Employing Dept. \_\_\_\_\_ Dept. ID \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signing this statement means that you have read and understand the policy.

**RETURN COMPLETED FORM TO:**

**New Employee: Submit to PAYROLL, PO BOX 7127 or FAX: 777-4721**

**For Form Revision: Submit to SAFETY & ENVIRONMENTAL HEALTH, PO Box 9031 or FAX: 777-4132**

*(Revised 2/06)*