TEXAS ASSOCIATION *of* COUNTIES
RISK MANAGEMENT POOL

Employee Acknowledgement of PSWCA Direct Contracting Program

I have received information that informs me of my employer's election to utilize the Political Subdivision Workers Compensation Alliance (Alliance) and how to obtain health care if I should suffer a work related injury/illness.

If I am injured on the job, I understand that:

1. I must choose a treating doctor from the list of contracted providers provided by my employer or obtain the list myself from **www.pswca.org**
2. I must go to my treating doctor for all health care related to my injury. If I need a specialist, my treating doctor will refer me. If I require emergency care I may go anywhere.
3. Making a false of fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.
4. Additional information regarding the Alliance is available on TACRMP's website at **www.county.org**

____
Signature Date

____
Printed Name

I live at ______________________________________
Street Address

____
City, State, Zip Code

Name of Employer

Please indicate whether this is the:

__ Initial Employee Notification

__ Date of Injury Notification (date of injury ___/___/____)

PLEASE RETURN THIS FORM TO YOUR EMPLOYER