



81 Makawao Avenue, Suite 202, Makawao, HI 96768 Tel.: 808/572-6454; Fax: 808/572-1788

Non-Binding Affirmation Regarding Medical Care

Employee Name:

Employer: Professional Business Services, Inc.

Policy Number: WC100-0003848-2019A

I have received from my employer information regarding occupational medicine and a network of employer-designated doctors and other practitioners. I understand that the goal of occupational medicine is to provide the right treatment at the right time so that injured employees may return to work timely and safely. I understand that it is to my benefit to consider medical provider options in advance rather than under stressful conditions immediately after an injury.

I know that, injured on the job, I have the right to select any medical provider regardless of whether they are designated by my employer, I understand that if 80% of my employer's employees provide a non-binding affirmation to utilize the services of the employer-designated medical providers, my employer may receive a workers' compensation policy safety credit. I know that my participation is entirely voluntarily, and I have determined it to be in my best interest. I know that I am not required to sign this form. I reserve the right to retract or amend this non-binding affirmation at any time by giving written notice to my employer of my intent to do so.

MARK ONE:

[X]I do []I do not (initial one) affirm my intention that if I am injured on the job I will select a medical provider from the list designated by my employer. I understand that this indication of intent is non-binding. I certify that this indication has not been obtained through pressure or coercion. I know this expression of intent does not alter my rights under Hawaii labor and workers' compensation laws.

Employee Signature _____ Date: _____

Witness Signature _____ Date: _____

Employer Signature _____ Date: _____

Designated Medical Providers for Professional Business Services, Inc.

Kaiser Permanente