WASHINGTON AND LEE UNIVERSITY
TREATMENT ACKNOWLEDGEMENT FORM FOR REPORTED INJURY AT WORK

TO: Doctor _____

Hospital: _____

This employee has chosen you for medical treatment for an injury reported at work.

Employee Name: _____

Date of Injury: _____ Body Part Injured: _____

Employer Name: Washington and Lee University Contact: Paul Burns, Director of
Employer Phone: 540-458-8175 Fax: 540-458-8952 Environmental Health & Safety

Presentation of this form is not an acceptance of compensability under state law, but does acknowledge that the employer is aware of the treatment request. If the request is not paid under Workers' Compensation coverage, only then should the bill go to the employee's health insurance provider:

_____

_____

_____

Please send bills for review by workers' compensation carrier to:

The Hartford
Sentinel Insurance Company, LTD.
One Hartford Plaza
Hartford, CT 06115

Policy # 14WE CM0437

Phone: 877-673-9222
FAX: 888-459-1618