MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

NOTICE AND ACKNOWLEDGEMENT OF RIGHT TO WORKERS' COMPENSATION BENEFITS

Injury Number

USE FOR ACCIDENTS INVOLVING LESS THAN $500 IN TOTAL MEDICAL COSTS AND NO LOST TIME FROM THE EMPLOYMENT, UPON RECEIPT OF THE NOTICE REQUIRED BY SECTION 287.380, RSMo.

1. Name of Employee	Address (Street, City & County)	State	Zip Code	Telephone Number
2. Name of Employer	Address (Street, City & County)	State	Zip Code	Telephone Number
3. Name of Insurer	Address (Street, City & County)	State	Zip Code	Telephone Number
4. Date of Accident/Injury	Location of Accident/Injury (Street, City & County)	State	Zip Code	Employee's Social Security

I, _____ (print/type name of employee), understand that on the _____ day of _____, 19 _____, while engaged in employment at _____ (location of accident), I suffered an injury or illness for which compensation is payable under the Missouri Workers' Compensation Law, and as an injured employee I am entitled to workers' compensation benefits. These benefits include:

(1) MEDICAL CARE TO CURE THE INJURY. The employer/insurer must provide all reasonable and necessary medical care to cure the injury/illness. There is no deductible, and all costs are paid directly by the employer/insurer (i.e. doctor bills, medicines, hospital costs, lab test fees, x-rays, crutches, etc. plus mileage). The employer/insurer, however, has the right to choose the doctor, medical facilities, etc., and is not required to pay for the cost of any treatment not authorized by them.

(2) CASH PAYMENT FOR LOST WAGES. If an employee is unable to work more than three regularly scheduled work days because of a work-related injury/illness, the employer/insurer must provide the employee with "temporary disability" payments until the doctor says the employee is able to return to work. (This benefit does not apply to employees who have not missed any time from work.)

(3) ADDITIONAL CASH PAYMENTS. Once medical treatment is completed and a determination has been made that the injury has resulted in permanent disability, the employer/insurer is responsible for "permanent disability" payments, with the amount of compensation being computed according to the disability schedule, as provided by law.

Also, I understand that if I do not act to secure the benefits in a timely manner I may forfeit my right to such benefits. An employee must file a claim for compensation within two (2) years of the date of the injury or the date of the last payment for medical treatment provided on account of the injury. (However, the two (2) year period is extended to three (3) years if the employer/insurer does not timely file the Report of Injury with the Division of Workers' Compensation.)

I solemnly swear or affirm under the penalty of perjury that I have read and understand the Notice and Acknowledgement of Right to Workers' Compensation Benefits; or, through an alternative format, I have been advised of and understand the Notice and Acknowledgement of Right to Workers' Compensation Benefits.

Employee	Date	Signature

CERTIFICATE:

The undersigned employer representative without admitting liability or the compensability of the alleged injury, certifies that a true and accurate copy of this notice has been hand-delivered to the above-referenced employee on this _____ day of _____, 19 _____, and is being mailed to the insurer named above, if applicable, and to the Division of Workers' Compensation accompanied by or affixed to the Report of Injury.

_____
Employer Representative