BISMARCK STATE COLLEGE

DESIGNATED MEDICAL PROVIDER

Name of Employee _____

I have been informed of BSC's Designated Medical Provider and the provisions of the North Dakota Risk Management Workers Compensation's requirements concerning treatment for workplace injury and illness.

Signature of Employee _____

Date _____

I wish to add the following provider as a designated provider to seek treatment from in the event of a workplace injury or illness.

Name _____

Address _____

_____

Name _____

Address _____

_____

Name _____

Address _____

_____

SUBMIT