Exhibit B-1

Notice of Preferred Provider Program
For Workers' Compensation Medical Care

Employee Acknowledgment Form

Please sign and date below to acknowledge your receipt of the Notice of Preferred Provider Program for Workers' Compensation Medical Care form from your employer at the time you reported your workers' compensation injury.

I am in receipt of this notice:

Received by:_____

Signature:_____

Name (please print):_____

Date Signed: _____