WORKERS COMP MEMORANDUM

I am aware of my requirements to notify my employer immediately if I am injured at work. At the time of hire this information was given and discussed with me. I understand my rights regarding workers' compensation injuries and filing a claim. I understand that injuries not reported immediately will result in corrective action. I have been provided with the Medical Physician Network (MPN) and realize that I must choose from those physicians to treat me if I have a workers' compensation injury. I understand if I do not treat with the physicians on the MPN, any charges associated with that treatment will not be paid by the employer or the Workers' Compensation Insurance Company. **I understand I will be required to take a post-accident drug test and refusal to do so could result in disciplinary action up to including termination.**

I have been provided with all this information in my native language and understanding all my rights under the law.

I understand that to make a false or fraudulent worker's compensation claim is against the law, and that Altman Plants will prosecute such claims to the fullest extent of the law, which would include restitution and possible jail time.

I DECLARE UNDER PENALTY OF PERJURY that the forgoing is true and correct.

Date:_____ Employee Signature:_____

Date:_____ Witness Signature:_____