



WORKERS' COMPENSATION WITH CARE®

**Employer MPN: Distribution & Acknowledgement Form**  
New Policy Only

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**Mandatory Acknowledgement of Receipt & Implementation of MPN**

On \_\_\_\_\_, I \_\_\_\_\_ distributed  
(date) (Company Representative First & Last Name)

The MPN Implementation Notice on Behalf of my employer by method of:

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(Describe method of distribution such as attached to paychecks, hand out, email)

to all employees of \_\_\_\_\_, Policy \_\_\_\_\_  
(Company Name) (Policy Number)

In addition, we have posted the red '**Notice to Employees – Injuries Caused by Work**' postings notices in an area accessible to all of our employees. We have also posted the '**Medical Provider Network (MPN)**' posters next to the red '**Notice to Employees – Injuries Caused by Work**' poster. We also agree to provide all new employees the MPN Implementation Notice as part of their new hire packet.

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(Signature of Company Representative)

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(Date)

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(Signature of Company Witness)

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(Date)

**Mail To:**  
CompWest Insurance Company  
PO Box 12859  
Newport Beach, CA 92658

**Fax To:** 866 540-3893

**Email to:** MPN@compwestinsurance.com



## Picture of Posting Notices

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Please provide a picture of your posting notices with the following information:

Date picture taken: \_\_\_\_\_

Who took the picture: \_\_\_\_\_

Job Title: \_\_\_\_\_

Where the poster is located: \_\_\_\_\_

A large, empty rectangular box with a black border, intended for the user to upload a photograph of their posting notices.