

# Bill's Equipment & Supply, Inc.

## >> New Employee Designated Provider Notification Letter

**To:** All Employees

**From:** Allison Brink, Office Manager, Bill's Equipment & Supply, Inc.

**Date:**

**Subject:** Designated Medical Providers for Work-Related Injuries and Illnesses

All employees must obtain treatment of work-related injuries and illnesses from one of the following medical providers:

**1. Name:** CONCENTRA MEDICAL CENTERS-SO  
**Address:** 2322 S ACADEMY BLVD  
**City, State & Zip:** COLORADO SPRINGS, CO 80916  
**Phone:** 719-390-1727  
**Fax:** 719-390-9690

**2. Name:** CCOM SISTERS GROVE  
**Address:** 6011 E WOODMAN RD, STE 100  
**City, State & Zip:** COLORADO SPRINGS, CO 80923  
**Phone:** 719-571-8888  
**Fax:** 719-571-8889

**3. Name:** MHS Occupational Health Center  
**Address:** Printers Park – 175 S Union, STE 315  
**City, State & Zip:** Colorado Springs, CO 80910  
**Phone:** 719-365-6840  
**Fax:** 719-365-6774

**4. Name:** Emergicare Medical Clinic - Bijou  
**Address:** 402 W Bijou  
**City, State & Zip:** Colorado Springs, CO 80905  
**Phone:** 719-302-6942  
**Fax:** 719-302-6686

In the event of a life- or limb-threatening emergency, the injured employee will be sent to the nearest emergency medical facility. One of the medical providers designated above must provide all follow-up care.

**If an unauthorized medical provider treats an employee, the employee will be responsible for payment for said treatment.**

I have read and am fully aware of the organization's policy regarding medical treatment for work-related injuries and illnesses. I further understand that I must immediately report any work-related injury to my supervisor.

All employees must sign below, acknowledging this policy.

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**Employee's name**

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**Employee's signature**

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**Date**