# Recommendation of Care Program (ROC)
# Acknowledgement Form

NYSIF Policyholder Name: ________________________________________________

Policy Number: _________________________________________________________

I am enrolling in the MetraComp Recommendation of Care Program (ROC) program through NYSIF.

I have been advised of New York ROC program requirements, inclusive of administration of the Form C-3.1, "Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider," and that any and all employee communications or postings under the ROC program **MUST** clearly indicate that the specified network of providers is strictly voluntary; that the injured worker may obtain a list of authorized health care providers from the NY Workers' Compensation Board; that the injured worker may choose or change a healthcare provider at will without jeopardizing medical or indemnity benefits; and that for the treatment of any work-related injury or illness, the injured worker retains the right to be treated by any physician, podiatrist, chiropractor, or psychologist who is authorized by the NYS Workers' Compensation Board.

Policyholder's Signature: _________________________________________________

Title: _________________________________________________________________

I understand that the effective date of this enrollment is: _______________________
*Date*