Employer:
Employee:
Date of Loss:
File Number:
State Case Num:

CHOICE OF PHYSICIAN FORM

EMPLOYEE: PLEASE READ, COMPLETE, AND SIGN BELOW.

EMPLOYEE NAME: ______________________________

ADDRESS: ______________________________
STREET CITY STATE/ZIP

TELEPHONE: ______________________________
AREA

DATE OF INJURY: ______________________________

CLAIM #: ______________________________

I understand that I have an initial choice of physicians for treatment of my job-related or occupational disease. I also understand that once I have been treated by a physician of my choice, I am not authorized to change physicians without first obtaining authorization from the Office of Workers' Compensation or the .

I DESIGNATE DR. ______________________________ AS MY CHOICE OF PHYSICIAN.
FIRST NAME LAST NAME

ADDRESS: ______________________________ ( )
STREET (PO BOX) CITY STATE, ZIP AREA TELEPHONE #

EMPLOYEE SIGNATURE: ______________________________

PRINT YOUR NAME: ______________________________ DATE: ______________________________