NOTICE TO THE MISSISSIPPI WORKER'S COMPENSATION COMMISSION OF

PHYSICIAN OF CHOICE

Employee's Name: ____

Employer's Name: ____

Date of Alleged Injury: ______________________

Claim Number: ______________________

I am claiming to have sustained an injury involving my ____________________________

I am _________ am not __________ claiming that my medical condition is work related.

I understand that under the MS Worker's Compensation Law I have the right to choose one (1) physician to render treatment to me.

I also understand that any referral to any other physician must be made by my one (1) chosen physician.

I also understand that my employer (or Worker's Compensation Carrier) must approve any physician change, and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment.

With that understanding, I state as follows:

_______ I accept as my choice of physician my employer's tender of treatment by

Dr. ____

_______ I elect to choose my own physician to render treatment, and that choice is

Dr. ____

____
Employee's Name Printed

____
Employee's Signature

____
Date

Witnessed by:

____

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<u>This Form Should Be Completed By Injured Employee Only</u>