NOTICE OF PHYSICIAN CHOICE

Employee's Name: _____

Employer's Name: _____

Injury Date: _____

I am claiming to have sustained an injury involving my _____. (indicate part of body)

I am _____ am not _____ claiming that my medical condition is work related. (check one)

If work related:

I understand that under the Mississippi Workers' Compensation Law I have the right to choose one (1) physician to render treatment to me. I can either accept the physician to whom I am sent by employer or choose someone else on my own.

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

I also understand that my employer (or workers' 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 suggested physician to provide treatment and that choice is Dr. _____

- ❑ I elect to choose my own physician to provide treatment and that choice is Dr. _____

_____
Employee's Signature

_____
Date

Witnessed By: _____

_____

Copy to Employee and Employer (within 24 hours)
Tate County School District Fax #: (662) 562-8516