NOTICE TO MISSISSIPPI WORKERS' COMPENSATION COMMISSION OF PHYSICIAN CHOICE

Claimant's Name _____

Employer's Name _____

Injury Date _____

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

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

I understand that under the Mississippi Workers' Compensation Law I have the right to choose one physician to render treatment to me. I can either accept the physician to whom I am sent to by my 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 if I change doctors without their authorization, I will be responsible for the medical expense 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. _____.

_____
Claimant's Signature

_____
Date

Witnessed by:

_____

_____