

RESPONSE TO PETITION FOR CHANGE OF PHYSICIAN

Employer Name and Address: Telephone Number:	Surety Name and Address: Telephone Number:
Employee Name and Address:	Additional Documentation to Support Decision (circle one): No <input type="checkbox"/> Yes <input type="checkbox"/>

Response to petition (circle one): **Approved** **Denied**

Reasons for Denial: Further medical treatment is not reasonable or necessary. _____

Other (Please explain) _____

Hearing Dates/Times Availability Next 14 Days: _____

Date: _____ **Signature:** _____

Typed/Printed Name: _____

Title: _____

Original to Idaho Industrial Commission, 700 South Clearwater Lane, PO Box 83720, Boise, ID 83720-0041, or faxed to the Commission at 208-332-7558.

Copy to Employee.

CERTIFICATE OF SERVICE

I hereby certify that on the _____ day of _____, 20____, I caused to be served the Original Response to Petition for Change of Physician upon:

Idaho Industrial Commission
700 South Clearwater Lane
Post Office Box 83720
Boise, Idaho 83720-0041

- via: Personal Service of Process
- Regular U. S. Mail
- Faxed to 208-332-7558

I also hereby certify that on the _____ day of _____, 20____, I caused to be served a true and correct copy of the foregoing Response to Petition for Change of Physician upon:

CLAIMANT'S NAME AND ADDRESS

- via: Personal Service of Process
- Regular U. S. Mail

Signature

Print or Type Name