## RESPONSE TO PETITION FOR CHANGE OF PHYSICIAN

Employer Name and A	Address:	Surety Name and	Address:	
Telephone Number:		Telephone Number:		
Employee Name and Address:		Additional Documentation to Support Decision (circle one):		
		No □ Yes □		
Response to petition (cir	rcle one): Approved	Denied		
	Further medical treatment is	not reasonable or neo	cessary	
□Other (Please explain	)			
Hearing Dates/Times A	availability Next 14 Days:			
Date:	Signature:			
	Typed/Printed Name:			
	Title:			
Original to Idaho Indu the Commission at 208-	strial Commission, PO Box 332-7558.	83720, Boise, ID	83720-0041, or faxed to	
Copy to Employee.				
(Rev. August 12, 2019)		Response - Pag	ge 1 of 2 – Appendix 7B	

## **CERTIFICATE OF SERVICE**

I here Original Rest	by certify that on theonse to Petition for Change	day of e of Physician up	, 20	_, I caused to be served the
	rial Commission Sox 83720	J 1		
via:	( ) Personal Service of P	rocess		
	( ) Regular U. S. Mail			
	( ) Faxed to 208-332-755	58		
I also true and corre	hereby certify that on the _ect copy of the foregoing Re	day ofesponse to Petition	, 20 on for Change	O, I caused to be served of Physician upon:
CLAIMANT	T'S NAME AND ADDRES	SS		
via:	( ) Personal Service of I	Process		
	( ) Regular U. S. Mail			
	( ) Faxed to 208-332-75	58		
		Sign	nature	
		Prin	t or Type Nam	e