

PETITION FOR CHANGE OF PHYSICIAN

Employee Name and Address: Telephone Number: Social Security Number:	Employer Name and Address:
Current Physician and Address:	Surety Name and Address (if known):
Requested Physician and Address:	Additional Information or Documentation Attached (Circle One): No <input type="checkbox"/> Yes <input type="checkbox"/>

Date of Injury/Disease: _____

Medical Treatment to Date: _____

Reason for Change: _____

Hearing Date/Time Availability Next 30 Days: _____

If the employer/surety responds that no further medical treatment is reasonable or necessary, then you must instead pursue your claim through the complaint process. You will be notified by mail if this is the case, and no hearing will be set.

Date: _____ Signature: _____

Typed/Printed Name: _____

ORIGINAL TO EMPLOYER OR SURETY

Copy to Idaho Industrial Commission, PO Box 83720, Boise, ID 83720-0041, or fax to 208-332-7558.

CERTIFICATE OF SERVICE

I hereby certify that on the ____ day of _____, 20____, I caused to be served the Original Petition for Change of Physician upon either the following Employer or its Surety:

EMPLOYER’S NAME AND ADDRESS

SURETY’S NAME AND ADDRESS

OR

via:

via:

Personal Service of Process

Personal Service of Process

Regular U. S. Mail

Regular U. S. Mail

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

Idaho Industrial Commission
Post Office Box 83720
Boise, Idaho 83720-0041

via: Personal Service of Process

Regular U. S. Mail

Faxed to 208-332-7558

Signature

Typed or Printed Name