GEORGIA STATE BOARD OF WORKERS' COMPENSATION
CHANGE OF PHYSICIAN/ADDITIONAL TREATMENT BY CONSENT

When properly executed and filed with the Board, with copies provided to the named medical provider(s), this form will be deemed approved, and made the order of the Board pursuant to O.C.G.A. §34-9-200(b).

A. IDENTIFYING INFORMATION

Employee Name _____ Soc. Security No. _____

Address _____ Date of Injury _____

_____ County of Injury _____

MCO ❑ Yes No ❑

B. PHYSICIANS/TREATMENT

1. The currently authorized treating physician is Dr.:

Name _____

Address _____

2. Authorization is requested for treatment by Dr.:

Name _____

Address _____

3. The additional treatment authorized is:

_____

_____

_____

C. AGREEMENT

_____ 1. The parties agree that a change in treating physician to Dr. _____ is authorized, and the employer is to be responsible for payment of necessary and reasonable medical expenses incurred as a result of treatment rendered to the employee by this physician effective ____/____/____.

_____ 2. The parties agree that additional medical treatment as noted above may be provided to the employee by Dr. _____, and the employer is to be responsible for the payment of necessary and reasonable medical expenses incurred as a result of this treatment, effective ____/____/____. The primary treating physician will remain Dr. _____.

This agreement made by:

_____ _____

Signature (Employee or Representative) Signature (Employer or Representative)

Type Name and Address: _____ Type Name and Address: _____

_____ _____

_____ _____

D. CERTIFICATION

I hereby certify that I have today sent a copy of this form to all parties, counsel and the above-named medical providers, and to the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299.

_____ _____

PRINT NAME HERE SIGNATURE

_____

DATE

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).