(TYPE YOUR COMPANY NAME HERE)

Workers' Compensation Panel of Physicians

Please decline or elect to receive medical treatment for your injury by placing a checkmark beside one of the two statements below.

☐ I decline treatment. I do not want to choose a panel physician.

☐ I elect to receive medical treatment. I want to choose a panel physician.

If you have elected to receive medical treatment, circle the name of the physician below that you would like to provide medical treatment to you.

Physician Name
Practice Name
Street Address
City, ST Zip
Phone:
Fax:

Physician Name
Practice Name
Street Address
City, ST Zip
Phone:
Fax:

Physician Name
Practice Name
Street Address
City, ST Zip
Phone:
Fax:

You acknowledge that you have either declined treatment or have elected to be treated by one of the panel physicians listed above. By signing this form, you also acknowledge that only one visit has been authorized with your chosen panel physician to date and if you choose to be seen by any other physician for this injury, you will be financially responsible for all related charges.

_____ _____
Employee Name (Print) Employee Signature

_____
Date

_____ _____
Employer Representative's Name (Print) Employer Representative's Title

_____
Date

FIRST Benefits
INSURANCE MUTUAL
WORKERS COMPENSATION