

NOTICE
TO
MISSISSIPPI WORKERS' COMPENSATION COMMISSION
OF PHYSICIAN CHOICE

Claimant's Name _____

Employer's Name _____

Injury Date _____

Claim Number _____

I understand that under the Mississippi Workers' Compensation Law I have the right to choose one physician to render treatment to me. I can either accept the physician to whom I am sent to by my employer or choose someone else on my own.

I also understand that any referral to any other doctor must be made by my one chosen physician.

I also understand that my employer (or workers' compensation carrier) must approve any physician change, and if I change doctors without their authorization, I will be responsible for the medical expense for the unauthorized treatment.

With that understanding I state as follows:

I accept as my choice of physician my employer's tender of treatment by
Dr. _____.

I elect to choose my own physician to render treatment, and that choice is
Dr. _____.

Claimant's Signature

Date

Witnessed by:
