

**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).