042

The Industrial Commission of Utah
160 East 300 South, Third Floor
P. O. Box 5800
Salt Lake City, UT 84110-5800

NOT APPROVED IF INCOMPLETE

APPLICATION TO CHANGE DOCTORS

On ________________, 19___, I, ____

Date of Injury — Name and complete address of Injured

sustained an injury arising out of or in the course of my employment, while employed by:

____

Name, Complete Address (Including Zip Code), and Phone number of Company

Briefly describe how accident occurred, parts of body injured, and results are: __________

____

____

I have been treated by the following doctors (Give full names and addresses in the order in which they were seen): ____

____

I have requested change from employer/Ins. Co. ___Yes ___No: Change was approved _ Yes __No

The insurance carrier is: ____

Give name, address, zip code, and phone number of

____

carrier and adjustor's name, if known

I asked my present doctor for a referral ___Yes ___No and he approved referral ___Yes ___No

I would like permission to change from Dr. ________________________________

Give full name, address, and title(M.D., D.C., etc.

____

____

to Dr. ____

My reasons for wanting to change are: ________________________________

____

____

________________________________ ________________________________

Printed name of Injured Person — Signature of Injured Person

________________________________ ________________________________

Number and Street Address — City and Zip Code

____

Phone Number

* * * * * * *

REQUEST APPROVED SUBJECT TO ANY DEFENSES THE EMPLOYER OR ITS INSURANCE CARRIER MAY HAVE

________________ Approved by ____

Date — Administrative Law Judge, Commissioner, Legal Asst.

Copies mailed on ________________, 19 , Request denied for the following reasons:
to the following:

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