Form 102

APPLICATION TO CHANGE DOCTORS

_____ Carrier File No. _____

Name of Injured Person

_____ Social Security No. _____

Home Address (street)

City/State/Zip Home Phone Number

On_____, 20_____, I sustained an injury/occupational disease arising out of and in the course of my employment at_____

Employer Name

Employer Address

City/ State/ Zip Phone Number

Briefly describe how accident occurred, parts of body injured, and results _____

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

I asked my present doctor for a referral. Yes_____No_____Referral was approved. Yes_____No_____
I would like permission to change from Dr. _____

(Give full name, title [M.D., D.C., etc.], address and zip)

To Dr. _____

(Give full name, title [M.D., D.C., etc.], address and zip)

My reasons for wanting to change are:

MAIL THIS REQUEST TO:
Insurance Carrier/Adjustor _____
Street or Mailing Address _____
City, State, Zip _____

ACTION ON REQUEST

Approved by:_____Date:__ Denied by:_____Date:__ Reasons for denial:_____

***Copies of this form approved or denied, must be mailed promptly to the applicant and to the doctor the applicant has requested to be the treating physician. Per R612-300-2, after an injured worker has exercised his or her one-time right to change health care providers, the worker must use this form to request payor approval of any subsequent change of provider.

UTAH LABOR COMMISSION
Industrial Accidents Division

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