

APPLICATION TO CHANGE DOCTORS

PLEASE PRINT OR TYPE

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.



Official Form 102 Revised 10/14

State of Utah * Labor Commission * Division of Industrial Accidents

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