

# MEDICAL TREATMENT PROVIDER LIST

PLEASE PRINT OR TYPE

Claimant Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Address \_\_\_\_\_ Date of Injury \_\_\_\_\_  
 \_\_\_\_\_ Employer \_\_\_\_\_  
 Telephone Number \_\_\_\_\_

**“Notification to the Workers’ Compensation Claimant”**

Per Labor Commission Rule R612-300-10, an injured worker who files a claim for workers’ compensation benefits is required, requested, to provide the name and address of medical providers who have provided any medical treatment for up to the past 10 years. This is your notice that any and all of the medical records within the custody of the medical provider that you have listed may be requested by the party named on this form, as authorized by Rule R612-300-10.\* The medical provider is required to release the medical records per the rule, in order for the insurance carrier, self-insured employer, or the Labor Commission to make a determination in your case.

\*You are required to sign the “Authorization to Release Medical Records” Form 308.

Please list all the medical providers for industrial injuries first.

Please list any other medical providers who have treated you for medical problems within the past \_\_\_\_\_ years (up to 10 years).

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Telephone Number \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
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 Telephone Number \_\_\_\_\_ Telephone Number \_\_\_\_\_

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 \_\_\_\_\_  
 \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Telephone Number \_\_\_\_\_

Please attach additional pages, if necessary.

Name of Party Requesting the Medical Records \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Fax \_\_\_\_\_  
 Relationship to the Claim \_\_\_\_\_

\*Medical Providers who have treated you related to your reproductive organs or for psychological problems do not have to be listed unless you have made a claim for benefits related to these medical problems.  
 Failure to return this form to the requester may result in a delay or denial of your claim.



**Official Form 307** Revised 03/15

**State of Utah \* Labor Commission \* Division of Industrial Accidents**

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