Name of Injured Person  Home Address (street)  City/State/Zip Home Phone Number  On, 20, I sustained an injury/occupational disease arising out of and 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 the seen):  I asked my present doctor for a referral. YesNoReferral was approved. YesNo 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:	Form 102	APPLICATION TO CHANGE DOCTORS
Social Security No.		Carrier File No
City/State/Zip Home Phone Number  Dn	Name of Injured Pers	
Dn	Home Address (stree	· · · · · · · · · · · · · · · · · · ·
Employer Name  Employer Address  City/ State/ Zip Phone Number  Briefly describe how accident occurred, parts of body injured, and results	City/State/Zip	Home Phone Number
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 the 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 Adjuster Email  ACTION ON REQUEST  Approved by: Date:		
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 the 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 Malling Address City, State, Zip Adjuster Email  ACTION ON REQUEST  Approved by: Date:	course of my employ	
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Briefly describe how accident occurred, parts of body injured, and results		Employer Address
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My reasons for wanting to change are:  MAIL THIS REQUEST TO: Insurance Carrier/Adjustor Street or Mailing Address City, State, Zip Adjuster Email  ACTION ON REQUEST  Approved by: Date:	To Dr	
Insurance Carrier/Adjustor	My reasons for w	
Adjuster Email		Insurance Carrier/Adjustor Street or Mailing Address
Approved by: Date:		Adjuster Email
Approved by: Date:	ACTION ON REQUES	<u>5T</u>
Denied by: Date:	Approved by:	Date:
	Denied by:	Date:
Reasons for denial:	Reasons for denial:	
this form approved or denied, must be sent promptly to the applicant and to the doctor the applicant at the treating physician. Per R612 200 2, after an injured worker has even is at his or her one time.	e the tre	ating physician. Per R612-300-2, after an injured worker has exercised his or her one-time right to oviders, the worker must use this form to request payor approval of any subsequent change of

UTAH LABOR COMMISSION Industrial Accidents Division

160 East 300 South 3<sup>rd</sup> Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610 Office: (801)-530-6800 Fax: (801)-530-6804 Toll Free: (800)-530-5090 <a href="https://www.laborcommission.utah.gov">www.laborcommission.utah.gov</a>