GEORGIA STATE BOARD OF WORKERS' COMPENSATION

CHANGE OF PHYSICIAN / ADDITIONAL TREATMENT BY CONSENT

Instructions: Prior to filing this form with the Board, a Form WC-1 or WC-14 must have been previously filed with the Board. When properly executed and filed with the Board, with copies provided to the named medical provider(s), this form will be deemed approved, and made the order of the Board pursuant to O.C.G.A. § 34-9-200 (b).

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Address		
E-mail Address		City	State	Zip Code

B. PHYSICIANS / TREATMENT

1. The currently authorized treating physician is Dr.: Name _____	Address		
	City	State	Zip Code
2. The Authorization is requested for treatment by Dr.: Name _____	Address		
	City	State	Zip Code

3. The additional treatment authorized is:

C. AGREEMENT

❑ 1. The parties agree that a change in treating physician to Dr. _____ is authorized, and the employer is to be responsible for payment of necessary and reasonable medical expenses incurred as a result of treatment rendered by this physician effective _____ / _____ / _____ .

❑ 2. The parties agree that additional medical treatment as noted above may be provided to the employee by Dr. _____ , and the employer is to be responsible for payment of necessary and reasonable medical expenses incurred as a result of treatment, effective _____ / _____ / _____ . The primary treating physician will remain Dr. _____ .

This agreement is made by:

Signature (Employee or Representative)	Signature (Employer or Representative)
Employee / Attorney Name – Print	Employer / Attorney Name – Print

Address			Address		
City	State	Zip Code	City	State	Zip Code
E-mail Address		GA Bar Number	E-mail Address		GA Bar Number

D. CERTIFICATION

❑ I hereby certify that I have today sent a copy of this form to all parties, counsel and the above-named medical providers, and to the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299

Signature	E-mail	Date	Phone Number

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).