

**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.	Date of Injury
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**A. IDENTIFYING INFORMATION**

<b>EMPLOYEE</b>	County of Injury	Mailing Address		
	E-mail Address	City	State	Zip Code

**B. PHYSICIANS / TREATMENT**

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

This agreement is made by:

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

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

**D. CERTIFICATE OF SERVICE**

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
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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.sbcw.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).