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

A. IDENTIFYING INFORMATION

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

B. PHYSICIANS / TREATMENT

1. The currently authorized treating physician is Dr.:

Name ______________________________

Mailing Address		
City	State	Zip Code

2. The Authorization is requested for treatment by Dr.:

Name ______________________________

Mailing 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 be Dr. ____________________ .

This agreement is made by:

____
Signature (Employee or Representative)

____
Employee / Attorney Name – Print

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

____
Signature (Employer or Representative)

____
Employer / Attorney Name – Print

Mailing Address		
City	State	Zip Code
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

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).