MISSISSIPPI MUNICIPAL SERVICE COMPANY

NOTICE TO THE MISSISSIPPI WORKER'S COMPENSATION COMMISSION OF

PHYSICIAN OF CHOICE

Employee's Name: _____

Employer's Name: _____

Date of Alleged Injury: _____

Claim Number: _____

I am claiming to have sustained an injury involving my _____

I am _____ am not _____ claiming that my medical condition is work related.

I understand that under the MS Worker's Compensation Law I have the right to choose one (1) physician to render treatment to me.

I also understand that any referral to any other physician must be made by my one (1) chosen physician.

I also understand that my employer (or Worker's Compensation Carrier) must approve any physician change, and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment.

With that understanding, I state as follows:

_____ I accept as my choice of physician my employer's tender of treatment by

Dr. _____

_____ I elect to choose my own physician to render treatment, and that choice is

Dr. _____

_____
Employee's Name Printed

_____
Employee's Signature

_____
Date

Witnessed by:

_____

_____

This Form Should Be Completed By Injured Employee Only