PETITION FOR CHANGE OF PHYSICIAN

Employee Name and Address: Telephone Number: Social Security Number:	Employer Name and Address:
Current Physician and Address:	Surety Name and Address (if known):
Requested Physician and Address:	Additional Information or Documentation Attached (Circle One): No ☐ Yes ☐

Date of Injury/Disease: _____

Medical Treatment to Date: _____

_____

_____

Reason for Change: _____

_____

Hearing Date/Time Availability Next 30 Days: _____

If the employer/surety responds that no further medical treatment is reasonable or necessary, then you must instead pursue your claim through the complaint process. You will be notified by mail if this is the case, and no hearing will be set.

Date: _____ Signature: _____

Typed/Printed Name: _____

ORIGINAL TO EMPLOYER OR SURETY

Copy to Idaho Industrial Commission, PO Box 83720, Boise, ID 83720-0041, or fax to 208-332-7558.

CERTIFICATE OF SERVICE

I hereby certify that on the _____ day of _____, 20___, I caused to be served the Original Petition for Change of Physician upon either the following Employer or its Surety:

EMPLOYER'S NAME AND ADDRESS		SURETY'S NAME AND ADDRESS
_____	OR	_____
_____		_____
_____		_____
via:		via:
( ) Personal Service of Process		( ) Personal Service of Process
( ) Regular U. S. Mail		( ) Regular U.S. Mail

I also hereby certify that on the _____ day of _____, 20___, I caused to be served a true and correct copy of the foregoing Petition for Change of Physician upon:

Idaho Industrial Commission
700 South Clearwater Lane
Post Office Box 83720
Boise, Idaho 83720-0041

via: ( ) Personal Service of Process

( ) Regular U. S. Mail

( ) Faxed to 208-332-7558

_____
Signature

_____
Typed or Printed Name