CHOICE OF HEALTH CARE PROVIDER FORM

It is your employer's policy to allow an employee who is injured on-the-job to choose their initial health care provider.

By signing below, you understand and acknowledge that your employer is not directing your initial Health Care Provider Choice. We reserve the right after sixty days to change your Health Care Provider to the provider of our choice.

Name: ______________________
(Please Print)
Signature: ______________________

Date: ______________________