SAVE PRINT CLEAR

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
ADMINISTRATIVE DIRECTOR
Post Office Box 420603
San Francisco, CA 94142

PETITION FOR CHANGE OF PRIMARY TREATING PHYSICIAN

(LABOR CODE § 4603 & TITLE 8, CALIFORNIA CODE OF REGULATIONS, § 9786)

(Print or Type Names and Addresses)

WCAB Case Nos. (If any):_____

EMPLOYEE: _____

EMPLOYEE'S ADDRESS:_____

EMPLOYEE'S ATTORNEY: _____

EMPLOYEE'S ATTORNEY'S ADDRESS_____

EMPLOYER:_____

EMPLOYER'S ADDRESS:_____

CLAIMS ADMINISTRATOR:_____

CLAIMS ADMINISTRATOR'S ADDRESS:_____

CLAIMS ADMINISTRATOR'S CLAIM NUMBER(S):_____

NAME OF PRIMARY TREATING PHYSICIAN _____

PRIMARY TREATING PHYSICIAN'S ADDRESS:_____

PHYSICIAN PANEL: List below the **NAMES, ADDRESSES and MEDICAL SPECIALTIES** (e.g.-orthopedics, cardiology, etc.) of a panel of FIVE (5) physicians (to include one chiropractor if the employee is being treated by a chiropractor) available to provide treatment of the employee's injury in the event this petition is granted.

1._____

2._____

3._____

4._____

5._____

Petitioner states that the following constitutes good cause for issuance of an *Order Granting Petition For Change Of Primary Treating Physician:* (Additional sheets may be attached if necessary)

NOTE: Attach to this Petition any supportive evidence (medical reports, declarations, etc.) that establishes good cause for the Petition to be granted. (See Title 8, California Code of Regulations, Section 9786)

VERIFICATION

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

EXECUTED AT _____, CALIFORNIA ON _____
(City) (Date)

BY: _____ // _____
Original Signature of Petitioner's Representative Preparing the Petition // Name of Petitioner's Representative Preparing the Petition (Print or type)

_____
(Address of Petitioner)

_____

YOU MUST ATTACH A PROOF OF SERVICE BY MAIL DECLARATION INDICATING THAT: (1) PART A (PETITION FOR CHANGE OF PRIMARY TREATING PHYSICIAN) *AND* PART B (RESPONSE TO PETITION FOR CHANGE OF PRIMARY TREATING PHYSICIAN) OF THIS FORM AND (2) ALL SUPPORTIVE EVIDENCE WERE MAILED TO THE EMPLOYEE OR THE EMPLOYEE'S ATTORNEY, AND THE PRIMARY TREATING PHYSICIAN.

Notice to Employee/Employee's Attorney and Primary Treating Physician:

Pursuant to Title 8, California Code of Regulations, Section 9786(d), you may file with the Administrative Director a RESPONSE to this petition within 20 days from the date the petition was served on you. Your Response must be submitted using the *Response to Petition for Change of Treating Physician* form which is contained in Part B on Pages 3 and 4 of this form. You may attach additional sheets as needed to the Response form.

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
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Post Office Box 420603
San Francisco, CA 94142

RESPONSE TO PETITION FOR CHANGE OF PRIMARY TREATING PHYSICIAN

(LABOR CODE § 4603 & TITLE 8, CALIFORNIA CODE OF REGULATIONS, § 9786(d))

(*Print or type names and addresses)*

WCAB Case Nos. (If any):_____

EMPLOYEE: _____

EMPLOYEE'S ATTORNEY_____

EMPLOYER:_____

CLAIMS ADMINISTRATOR:_____

CLAIMS ADMINISTRATOR'S CLAIM NUMBER:_____

NAME OF PRIMARY TREATING PHYSICIAN _____

The petition filed by or on behalf of the Claims Administrator does not establish good cause for the issuance of an *Order Granting Petition For Change Of Primary Treating Physician based on the following:* (additional sheets may be attached if necessary)

IMPORTANT: Attach to this Response any supportive documentary evidence (medical reports, affidavit and declaration, etc.) which establishes that there is not good cause for the Administrative Director to grant the Petition for Change of Primary Treating Physician. (See *Title 8, California Code of Regulations, § 9786)*

VERIFICATION

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

EXECUTED AT _____, CALIFORNIA ON _____
(City) (Date)

BY: _____//_____
Original Signature of Person Preparing the Response // Name of Person Preparing the Response (Print or type)

Address:

_____

***NOTICE TO EMPLOYEE/EMPLOYEE'S ATTORNEY*: THE PROOF OF SERVICE BY MAIL DECLARATION BELOW MUST BE COMPLETED INDICATING A COPY OF THIS RESPONSE HAS BEEN MAILED TO THE CLAIMS ADMINISTRATOR OR ITS ATTORNEY, AND THE PRIMARY TREATING PHYSICIAN.**

***NOTICE TO PRIMARY TREATING PHYSICIAN*: THE PROOF OF SERVICE BY MAIL DECLARATION BELOW MUST BE COMPLETED INDICATING A COPY OF THIS RESPONSE HAS BEEN MAILED TO THE CLAIMS ADMINISTRATOR OR ITS ATTORNEY, AND THE EMPLOYEE OR THE EMPLOYEE'S ATTORNEY.**

PROOF OF SERVICE BY MAIL

On _____I served a copy of this Response to Petition for Change of Treating Physician on
(date)
_____ at _____and
(Claims Administrator or its Attorney) *(address)*
_____ at _____by
(Primary Treating Physician or Employee/ Employee's Attorney) *(address)*

placing a true copy enclosed in a sealed envelope, addressed as indicated above and with postage fully prepaid, in the U.S. Mail at_____, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____//_____
Original Signature of Declarant // Name of Declarant (Print or Type)