

WORKERS' COMPENSATION

Panel Physicians Form



The Virginia Workers' Compensation law requires your employer to provide to you a Panel of at least three physicians. You must select a physician from this Panel to treat your work-related injury. If you do not use one of these physicians for your work-related injury, you may be responsible for the cost of medical care.

Please select a physician from this Panel, complete and sign this form and return it to your supervisor.

The supervisor should immediately return this form to **MC INNOVATIONS (MCI)**
P.O Box 1140, Richmond, VA 23218-1140 Phone 804/649-2288 Fax 804/371-2556
E-mail COVimaging@yorkrsg.com

Please choose from the following list by writing the physician's name and signing the form. Return the form to your supervisor for filing with the claim application.

1) _____ NAME	2) _____ NAME	3) _____ NAME
_____ ADDRESS	_____ ADDRESS	_____ ADDRESS
_____ PHONE	_____ PHONE	_____ PHONE

Employee

By signing this form, I release all medical information to MC Innovations (MCI). All information will be considered confidential and used only in the matter of the workers' compensation claim.

I have been presented with a panel of at least three physicians and have selected:

Dr. _____ to provide me with medical care for my work-related injury.

Signed: _____ Date: _____
NAME

Printed: _____ Date of Injury: _____
NAME