EMPLOYEE'S CHOICE OR CHANGE OF DOCTOR FORM

NOTICE TO EMPLOYER: GIVE THIS FORM TO THE INJURED WORKER AS SOON AS POSSIBLE AFTER EACH INJURY

A: RIGHTS OF THE EMPLOYEE

Under the Nebraska workers' compensation laws, you may have the right to choose a doctor to treat you for your work related injury. You may choose a doctor who has treated you or an immediate family member before this injury happened. Immediate family members are your spouse, children, parents, stepchildren and stepparents. The doctor you choose must have records to show that past treatment was provided. Your employer may ask the person who was treated to give permission so the doctor can verify past treatment.

If you want to choose your doctor, you must tell your employer the name of the doctor you choose. Do this as soon as possible after your employer gives you this notice and before getting any treatment unless it is emergency medical treatment. Once you tell your employer the name of the doctor, you may not change your choice unless your employer agrees or the Nebraska Workers' Compensation Court orders a change.

If you do not choose your doctor, your employer has the right to choose the doctor to treat you. The employer may also choose the doctor to treat you if you or your family member does not give permission so your employer can verify past treatment by the doctor you chose.

You may choose a doctor if your claim is denied. You may also choose the doctor to do major surgery or for an amputation.

You may use part B below to tell your employer the name of the doctor you choose.

B: CHOICE OF DOCTOR

☐ I choose the following doctor to treat me for this work related injury. I certify that this doctor has treated me or an immediate family member before the work related injury.

☐ I do not have or I do not wish to choose a doctor who has treated me or an immediate family member.

_____ _____

DOCTOR'S NAME *SIGNATURE OF EMPLOYEE*

_____ _____

DOCTOR'S ADDRESS *DATE*

C: USE TO CHANGE THE CHOICE MADE IN PART B, ABOVE

I wish to change my choice of doctor or I wish to choose a doctor to treat me for my work related injury. I certify the doctor named below has treated me or an immediate family member before this work related injury. I understand that I cannot make this change unless my employer agrees or unless the Nebraska Workers' Compensation Court orders a change.

_____ _____

DOCTOR'S NAME *SIGNATURE OF EMPLOYEE* *DATE*

_____ _____

DOCTOR'S ADDRESS *SIGNATURE OF EMPLOYER* *DATE*