



## Panel Acknowledgement and Physician Selection

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By signing this form, I accept my employer's posted medical provider panel. I understand that I must choose a provider from the panel list to give me treatment for a work injury or illness. I also understand that if I get treatment from a provider that is not listed on the panel, my employer may not be required to pay for such treatment.

I also understand that I have the right to change to another provider listed on the panel if I am not satisfied with the first doctor I choose. I must obtain approval for any further provider changes from the insurance company or the Georgia State Board of Workers' Compensation.

I choose the following medical provider to give me treatment and services for my work injury or illness:

Provider/Physician Name \_\_\_\_\_  
Clinic Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

I have read this document. I fully understand its entire contents. I have asked questions about anything that was not clear to me. I am satisfied with the answers I have received. I understand I have a right to ask for a copy of this.

Signature \_\_\_\_\_  
Printed Name \_\_\_\_\_

Date \_\_\_\_\_