

NOTICE OF INTENT TO CHANGE HEALTH CARE PROVIDER

Note: An employee has the right to change health care providers from the one assigned to them by their employer, **regardless** of the reasons for the change, at **any time** during the course of treatment after the first appointment.

Employee Name: _____ Today's Date: _____
Please Print

School : _____ Date of Injury: _____

I am changing my medical care for my work-related injury from the first treating health care provider selected by my employer to the provider of my choice.

FIRST TREATING PROVIDER

NEW TREATING PROVIDER

Name: _____

Name: _____

Address: _____

Address: _____

City/State/Zip: _____

City/State/Zip: _____

- I am changing because:
- I would rather treat with my family health care provider.
 - I believe another health care provider is better able to treat my symptoms.
 - I have previously treated with another health care provider.
 - Other (please describe below):

This notice should be presented to the employer/insurance carrier prior to changing health care providers to fulfill the requirements of Vermont law, [21 V.S.A. § 640(b)]. Notice is not required for subsequent changes of provider after the first change of provider form is submitted.

Employee Signature

Date

for more
information :

