# Employee's Choice of Physician Form

I understand that I have the right to accept the services of a physician furnished by LUBA or select one physician to be my treating physician for my workers compensation claim.

I choose as my treating physician, Dr. _____.

I understand that any additional selection of physicians or further referrals must be approved by LUBA prior to obtaining the services of the physician. If approval is denied, I understand I may apply to the Mississippi Workers Compensation Commission for review of the decision to deny my request.

_____

DATE SIGNATURE OF EMPLOYEE/PRINTED NAME

_____

DATE SIGNATURE OF EMPLOYER REPRESENTATIVE