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Workers' Compensation Commission

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE
OKLAHOMA CITY, OKLAHOMA 73105

THIS SPACE FOR COMMISSION USE ONLY

In re Claim of:

Full Name of Claimant (Injured Employee)	
Claimant's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-_____	
Name of Employer (Respondent)	COMMISSION FILE NO.
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insured or Own Risk Group, Uninsured	Date of Injury

CC-FORM-A ORDER FOR CHANGE OF TREATING PHYSICIAN

NOW on this _____ day of _____, _____, the Workers' Compensation Commission, being well and fully advised in the premises, FINDS AND ORDERS AS FOLLOWS:

THAT the claimant is not covered by a Certified Workplace Medical Plan.

THAT the respondent admits claimant sustained a compensable injury arising out of and in the course of employment with respondent on the date above stated to the _____ *[state injured body part(s)]*.

THAT the claimant's application for change of treating physician pursuant to 85A O.S., §56(B) is proper and hereby granted.

IT IS THEREFORE ORDERED that Dr. _____ is designated as the claimant's treating physician for treatment of the claimant's _____ *[state injured body part(s)]*.

IT IS FURTHER ORDERED that per 85A O.S., §50, the designated treating physician shall provide the claimant such medical, surgical, hospital, optometric, podiatric, and nursing services, crutches and other apparatus as may be reasonably necessary in connection with the injury to the _____ *[state injured body part(s)]*, received by the employee, subject to the diagnostic testing limitation in 85A O.S., §50(C), the Workers' Compensation Commission's closed formulary pursuant to Commission Rule 810:15-5-2, and treatment guidelines of the *Official Disability Guidelines* published by the Work Loss Data Institute or Physician Advisory Committee Guidelines (PACG) and protocols, if applicable as provided by law.

The employer/respondent shall provide the designated physician with a file-stamped copy of this order.

BY ORDER OF _____
WORKERS' COMPENSATION COMMISSION ADMINSTRATIVE LAW JUDGE

Signature:	Signature:
Claimant/Counsel OBA# Print:	Employer-Respondent/Counsel OBA# Print:
Address (Number and Street)	Address (Number and Street)
City State Zip	City State Zip

Revised 12-18-14