WORKERS' COMPENSATION

Panel Physicians Form

The Virginia Workers' Compensation law requires your employer to provide to you a Panel of at least three physicians. You must select a physician from this Panel to treat your work related injury. *If you do not use one of these physicians for your work related injury, you may be responsible for the cost of medical care*.

Please select a physician from this Panel, complete and sign this form and return it to your supervisor. The supervisor should immediately return this form to **M C INNOVATIONS (MCI)**
P.O Box 1140, Richmond, VA 23218-1140 Phone 804/649-2288 Fax 804/371-2556
E-mail COVimaging@yorkrsg.com

Please choose from the following list by writing the physician's name and signing the form. Return the form to your supervisor.

1)	2)	3)
NAME	NAME	NAME
ADDRESS	ADDRESS	ADDRESS
PHONE	PHONE	PHONE

Employee

By signing this form, I release all medical information to M C Innovations (MCI). All information will be considered confidential and used only in the matter of the workers' compensation claim.

I have been presented with a panel of at least three physicians and have selected:

Dr. _____ to provide me with medical care for my work related injury.

Signed: _____ Date: _____

Printed: _____ Date of Injury: _____
NAME

Agency Representative: _____ _____ _____
Printed Name Signature Date

Revised 6/14