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