Mail to:	DOL Form 8 Rev. 9/11
Insurance Carrier Name:	State File No.
Insurance Carrier Address:	Ins. Co. File No.
Insurance Carrier City/State/Zip:	Date of Injury
Insurance Carrier Adjuster:	

## NOTICE OF INTENT TO CHANGE HEALTH CARE PROVIDER

Note: An employee has the right to change health care providers from the one suggested or 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:	
Address:	
City/State/Zip:	Home Telephone:
E-mail Address:	Work Telephone:

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:Address:		Name:
		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.

Print Employee Name



Employee Signature