Omaha Fire Department	Title of Document: **Employee's Choice or Change of Doctor Form**	
	Document Type & Number: **OFD Employee's Choice or Change of Doctor Form**	
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PARTS A & B ARE REQUIRED TO BE COMPLETED

PART A: NOTICE REGARDING CHOICE OR CHANGE OF DOCTOR

Under the Nebraska workers' compensation laws, you may have the right to choose a doctor to treat you for your work-related injury. You may choose a doctor who has treated you or an immediate family member before this injury happened. Immediate family members are your spouse, children, parents, stepchildren, and stepparents. The doctor you choose must have records to show that past treatment was provided. Your employer may ask the person who was treated to give permission, so the doctor can verify past treatment.

If you want to choose your doctor, you must tell your employer the name of the doctor you choose. Do this as soon as possible after your employer gives you this notice and before getting any treatment, unless it is emergency medical treatment. Once you tell your employer the name of the doctor (Part B), you may not change your choice unless your employer agrees or the Nebraska Workers' Compensation Court orders a change.

If you do not choose your doctor, your employer has the right to choose the doctor to treat you. The employer may also choose the doctor to treat you, if you or your family member does not give permission so your employer can verify past treatment by the doctor you chose.

You may choose a doctor if your claim is denied. You may also choose the doctor to do major surgery or for an amputation.

☐ **My employer has informed me of the above information regarding choice or change of doctor.**

PART B: CHOICE OF DOCTOR (choose one or more sections that apply)

☐ I choose the following doctor for treatment of this work-related injury. I certify that this doctor has treated me or an immediate family member before the work-related injury occurred.

Name of Doctor _____ **Dr.'s Phone #** _____
Dr.'s Address _____

☐ In the event my choice of doctor is not available to treat me immediately, I give consent for _____ to treat me for a one-time evaluation.

☐ I do not have or I do not wish to choose a doctor who has treated me or an immediate family member.

PART C: USE TO CHANGE THE CHOICE MADE IN PART B, ABOVE

I wish to change my choice of doctor or I wish to choose a doctor to treat me for my work-related injury. I certify the doctor named below has treated me or an immediate family member before this work-related injury. I understand that I **cannot** make this change unless my employer agrees or unless the Nebraska Workers' Compensation Court orders a change.

Name of Doctor _____ **Doctor's Phone #** _____

Doctor's Address _____

☐ **By checking this box and typing my name _____, I certify that all information on this form is true and correct. I also agree that the checkbox and my typed name serve as my electronic signature.**