

## NOTICE OF INTENT TO CHANGE HEALTH CARE PROVIDER

Note: An employee has the right to change health care providers from the one 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: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Please Print

School : \_\_\_\_\_ Date of Injury: \_\_\_\_\_

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: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

for more  
information :

