

**FORM A-ORDER**

**WORKERS' COMPENSATION COURT  
1915 NORTH STILES  
OKLAHOMA CITY, OKLAHOMA 73105-4918**

**In re Claim of:**

Full Name of Claimant (Injured Employee)	
Claimant's Social Security Number	
Name of Employer (Respondent)	Court Claim Number
Employer's Insurance Carrier, Own Risk Group or Individual Self-Insured Permit Number	Date of Injury

**ORDER APPROVING CHANGE OF PHYSICIAN SELECTED BY EMPLOYER**

[For use ONLY if the worker is NOT subject to a Certified Workplace Medical Plan (CWMP).]

NOW on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, the Workers' Compensation Court, being well and fully advised in the premises, FINDS AND ORDERS AS FOLLOWS:

THAT pursuant to 85 O.S., § 14(G), claimant's Application for Change of Physician for treatment of claimant's \_\_\_\_\_ (state injured body part) should be and is hereby granted.

THAT claimant presented to the employer/respondent the following list of three (3) physicians qualified to treat the claimant's injured body part for which the change of physician is sought: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_.

THAT of the names presented by the claimant, employer/respondent has selected Dr. \_\_\_\_\_ to treat claimant's injured body part for which this change of physician is sought.

IT IS THEREFORE ORDERED, that the employer/respondent shall furnish the claimant herein such treatment by Dr. \_\_\_\_\_ as may be reasonable and necessary for injury to claimant's \_\_\_\_\_, (state injured body part) and that such treatment shall be at the employer/respondent's expense.

BY ORDER OF \_\_\_\_\_  
WORKERS' COMPENSATION COURT JUDGE

A copy hereof was mailed, postage prepaid, by United States regular mail on this file-stamped date to all attorneys of record and to unrepresented parties, as follows:

Claimant/Counsel	Employer-Respondent/Counsel
Address (Number and Street)	Address (Number and Street)
City State Zip	City State Zip