

EMPLOYEE'S NOTIFICATION OF INTENT TO LEAVE LOCALITY OR STATE, AND TO CHANGE DOCTOR OR HOSPITAL

This form must accompany Form 043.

NOTICE: Injured employees should contact the insurance carrier prior to making plans to leave the state for medical care. **THE CARRIER MAY NOT BE LIABLE FOR ANY OR ALL OF THE COSTS.** Other states are not bound by our limitations on medical fees and you may have to pay the difference between what is allowed in Utah and what the new physician charges. If you have a question as to who the carrier is, ask your employer.

INCOMPLETE OR UNSIGNED FORMS WILL BE RETURNED. NO ACTION WILL BE TAKEN UNTIL THE ATTENDING PHYSICIAN'S STATEMENT (FORM 043) IS RECEIVED.

Name of Employer

Date of Injury

Street Address of Employer

Insurance Carrier

City, State and Zip of Employer

Employer's Area Code and Telephone #

Name of Employee (Printed)

Utah Street Address of Employee

New Address of Employee

Utah City and Zip Code of Employee

New City, State and Zip Code of Employee

Utah Phone #

SS#

New Area Code and Phone #

I left/intend to leave (circle one) the state on (date)_____. I have/have not (circle one) reported to my last Utah physician_____ for a current examination.

(Physician full name and title)

(Physician's complete address, including zip and office number)

(Please check): The Attending Physician's Statement (Form 043) describing my condition when last examined is attached to this request. (This form will not be processed without accompanying Form 043.)

The treating physician that I have chosen in my new location is:

Dr. _____

Name (including title)

Address, Office #, City, State & Zip

Area Code and Phone Number

Employee's Signature

Receipt acknowledged by: _____ Date: _____

Copies mailed to: _____

Mail completed form to: Utah Labor Commission – Industrial Accidents Division at address below.

