WORKERS' COMPENSATION COMMISSION

Disputed Provider/Practitioner Selection

SECTION I: This form is to be used when the parties cannot agree on a provider/practitioner of vocational rehabilitation services. Within five days of notice of a selection dispute, the parties must identify three provider/practitioners and submit this form to the Commission electronically. Please ensure that all parties are notified of the submission of this form.

WCC Claim #:

Claimant:

Employer:

Insurer:

SELECTION:

1. Provider name: _____ WCC Number: _____

   Practitioner name: _____ WCC Number: _____

2. Provider name: _____ WCC Number: _____

   Practitioner name: _____ WCC Number: _____

3. Provider name: _____ WCC Number: _____

   Practitioner name: _____ WCC Number: _____

Filed by: ☐ Claimant/Claimant's Attorney ☐ Employer/Insurer's Attorney ☐ SIF/UEF

Telephone: _____

Filed By: **Received:**

SECTION II: This section is to be used to strike two of the other party's selections (above). Within 5 business days of the filing date of Section I, this Section II must be filed with the Commission by HAND DELIVERY OR by FAX to 410-864-5251.

Strikes:

1. Provider/Practitioner name _____

2. Provider/Practitioner name: _____

Filed by: ☐ Claimant/Claimant's Attorney ☐ Employer/Insurer's Attorney ☐ SIF/UEF

Submitter's Name	Date	Telephone

CERTIFICATION OF SERVICE

I hereby certify that on this _____ day of _____ , _____ , I ☐ hand delivered ☐ FAXed to ( ) _____ a copy of this Disputed Provider/Practitioner Selection to all parties and their attorneys.

Signature	Telephone