

Medical Record Information
(Workmen's Comp. Claim Form)

AR-4030

RIGHTS OF THE EMPLOYEE.

Under the Nebraska worker's compensation laws, you may have the right to choose a doctor to treat you for a work related injury. You may choose a doctor who has treated you or an immediate family member before the injury happens. An immediate family member is your spouse, children, parents, stepchildren, and stepparents. The doctor you choose must have records to show that previous treatment was provided or that the individual has been recommended by the individual's personal physician. The school district may ask that you or your family member sign an authorization to verify the previous treatment.

You may tell school officials which doctor you choose at any time before the injury happens or you may tell your employer as soon as you reasonably can after an injury. If you change your choice, you must report it to the office of the superintendent. You cannot change your choice if the doctor you previously chosen has already treated you for the work related injury unless your employer agrees or unless the Nebraska Workers' Compensation Court orders a change.

If you do not choose your doctor, then the school district has the right to choose the doctor to treat you. The school district may also choose the doctor to treat you if you or your family member does not sign an authorization to verify the previous treatment by your doctor.

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

I acknowledge that my employer has given me this information about my right to choose a doctor under the Nebraska worker's compensation laws.

Signature of Employee

Date

CHOICE OF DOCTOR.

___ I choose the following doctor to treat me for work related injuries. I certify that this doctor has treated me or an immediate family member before the work related injury.

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

Doctor's Name

Signature of Employee

Address

Date

CHANGE IN CHOICE.

I wish to change my choice of doctor or I wish to choose a doctor to treat me for work related injuries. Effective on the date below, I choose the following doctor. I certify that this doctor has treated me or an immediate family member before the work related injury. I understand that I can change my choice of doctor again any time before a work related injury happens or as soon as I reasonably can after such injury. If I change my choice of doctor, I understand that I must tell my employer before the new doctor can treat me. I understand that I cannot change my choice if my previously chosen doctor has already treated me for the work related injury unless my employer agrees or unless the Nebraska Worker's Compensation Court orders a change.

Doctor's Name

Signature of Employee

Address

Date

In case of an emergency I authorize school officials to contact the following area doctor and/or hospital. If no doctor or hospital is listed in this area school officials shall contact a doctor or hospital of their choice.

Doctor's Name

Hospital

In case of an emergency I authorize school officials to notify the following next of kin or individual of my illness or condition.

Person

Telephone Number

Address

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