

Treating Doctor Selection Form

Instructions: Injured worker should indicate their initial choice of treating doctor from the Alliance Provider List. The completed form should be submitted to: TWCA Risk Management Fund
P.O. Box 26655
Austin, Texas 78755-0655
(Fax: 512-346-9321)

Employee's Name (Last, First, M.I.)		Treating Doctor's Name and Title	
Mailing Address	County of Residence	Mailing Address	
City State Zip Code	Phone Number	City State Zip Code	Doctor's Phone Number
Date of Birth	Date of Injury	Employer's Name	Employer's Phone Number
Have you returned to work? <input type="checkbox"/> Full Duty <input type="checkbox"/> Light Duty <input type="checkbox"/> No, not at all		Employer's Mailing Address	

SELECTED TREATING DOCTOR:

Requested Treating Doctor's Name	Title
Mailing Address	Telephone Number
License Number	