STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

DWC PETITION FOR SUSPENSION OR REVOCATION OF A MEDICAL PROVIDER NETWORK FORM 9767.17.5

(Print or Type)

NAME OF PETITIONER: _____PHONE:_____

PETITIONER'S
ADDRESS_____

PETITIONER'S E-MAIL ADDRESS_____

PETITIONER IS: ____INJURED WORKER ____EMPLOYEE/EMPLOYER REPRESENTATIVE OTHER _____

EMPLOYER (if applicable): _____

EMPLOYER'S ADDRESS:_____

MPN APPLICANT NAME: _____ MPN APPROVAL/LOG NO: _____

NAME OF MPN: _____

MPN'S ADDRESS: _____

MPN'S AUTHORIZED INDIVIDUAL: _____PHONE: _____

NAME OF MPN CONTACT:_____MPN CONTACT PHONE: _____

MPN CONTACT E-MAIL ADDRESS _____

DATE MPN CONTACTED: _____ IMMINENT THREAT TO HEALTH OF INJURED WORKER? ____ YES ____NO

CHECK BASIS FOR PETITION:

_____THE MPN APPLICANT DOES NOT MEET ELIGIBILITY REQUIREMENTS TO HAVE AN MPN; OR

_____THE MPN HAS FAILED TO MEET ACCESS STANDARDS FOR COMMONLY USED SPECIALTY(IES) LISTED IN THE APPLICATION IN THE FOLLOWING LOCATIONS OR SPECIALTY(IES) IN THE MPN GEOGRAPHIC SERVICE AREA:

LOCATION: _____ SPECIALTY: _____

LOCATION: _____ SPECIALTY _____

LOCATION: _____ SPECIALTY: _____

STATE REASONS FOR PETITION (Additional sheets and supporting documentary evidence may be attached):

VERIFICATION

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

EXECUTED AT _____, CALIFORNIA ON _____
City Date

BY: _____ _____
Original Signature of Petitioner Name of Petitioner

_____
Address of Petitioner

YOU MUST ATTACH A PROOF OF SERVICE BY MAIL DECLARATION INDICATING THAT: (1) PART A (DWC PETITION FOR SUSPENSION OR REVOCATION OF A MEDICAL PROVIDER NETWORK) *AND* PART B (MPN RESPONSE TO DWC PETITION FOR SUSPENSION OR REVOCATION OF A MEDICAL PROVIDER NETWORK) OF THIS FORM AND (2) ALL SUPPORTIVE EVIDENCE WERE MAILED TO THE ADMINISTRATIVE DIRECTOR AND A COPY TO THE MPN AUTHORIZED INDIVIDUAL.

Notice to Medical Provider Network:

Pursuant to Title 8, California Code of Regulations, Section 9767.17(d), you may file with the Administrative Director a RESPONSE to this petition within 30 days from the date the petition was served on you. Your Response must be submitted using the *MPN Response to DWC Petition for Suspension or Revocation of A Medical Provider Network* form which is contained in Part B on Pages 3 and 4 of this form. You may attach additional sheets as needed to the Response form.