# MPN RESPONSE TO DWC PETITION FOR SUSPENSION OR REVOCATION OF A MEDICAL PROVIDER NETWORK FORM 9767.17.5

(***Print or type)***

NAME OF PETITIONER: _____MPN APPLICANT NAME: _____

MPN NAME:_____ MPN APPROVAL/LOG NO: _____

NAME OF MPN CONTACT:_____ MPN CONTACT PHONE: _____

**THE DWC PETITION FOR SUSPENSION OR REVOCATION OF A MEDICAL PROVIDER NETWORK SHOULD NOT BE GRANTED BASED ON THE FOLLOWING: (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 _____, _____ ON _____
(City) (State) (Date)

BY: _____//_____
Original Signature of MPN Authorized Individual // Name of Authorized Individual

Address: _____

***NOTICE TO MPN*: THE PROOF OF SERVICE BY MAIL DECLARATION BELOW MUST BE COMPLETED INDICATING A COPY OF THIS RESPONSE HAS BEEN MAILED TO THE ADMINISTRATIVE DIRECTOR AND THE PETITIONER.**

## PROOF OF SERVICE BY MAIL

On _____I served a copy of this MPN Response to DWC Petition for Suspension or
*(Date)*

Revocation of a Medical Provider Network on _____at_____
*(Petitioner)* *(Petitioner's address)*

and the Administrative Director of the Division of Workers' Compensation at _____
*(Address)*

by placing a true copy enclosed in a sealed envelope, addressed as indicated above and with postage fully prepaid, in the U.S. Mail at_____, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____//_____
Original Signature of Declarant // Name of Declarant