Designated Medical Provider (DMP) Selection Form

This form should be kept by the employer and a copy given to the employee for their records.

The designated medical provider(s) for (employer's name) are

Provider's name	**Provider's address**	**City**	**State**	**Telephone number**

I have been informed of my employer's DMP program

Employee's signature	**Employee's name (please print)**	**Date**

I wish to add the following designated medical provider(s) to seek treatment from in the event of a workplace injury or illness

Provider's name	Provider's address	
City	State	ZIP code
Provider's name	Provider's address	
City	State	ZIP code
Provider's name	Provider's address	
City	State	ZIP code

I have added the above designated medical provider(s)

Employee's signature	**Employee's name (please print)**	**Date**