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

Petitioner to complete all required fields and state the reasons for this Petition with sufficient details below

First Name	Last Name	Phone	Number	Petitioner E-mail
Mailing Address	City			State Zip Code
In what capacity are you fi	ling this petition (Check one)	: Injured Worker	Repre	esentative
If you selected "Other," ple	ease explain:			
	MPN	Information		
MPN Name		MPN Applicant Name		MPN Identification No
	MPN Con	tact Information		
MPN Contact First Name	MPN Contact Last Name	MPN Contact E-mail		MPN Contact Phone
	Basis for Pe	tition (Select one)		
The MPN Applicant	does not meet eligibility requ	uirements to have an MPN		
occasion in at least to worker being unable	natically failed to meet MPN wo specific locations within to obtain necessary treatment each occasion and location.	the MPN geographic service	ce area. Tl	his failure resulted in a
State Reasons for Petition	(additional pages and docu	ments may be attached):		
	V	erification		
I declare under penalty of p	perjury under the laws of the	State of California that th	e foregoing	g is true and correct.
Executed at City				
-		(MN	A/DD/YYYY)	
Name of Petitioner	By:	Signature of Petitione	ar.	
		Signature of rentions	√ l	

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

NOTICE TO PETITIONER:

You must attach a Proof of Service by Mail indicating that 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 with all supporting evidence were mailed to the Administrative Director and a copy sent to the MPN's authorized individual.

NOTICE TO MEDICAL PROVIDER NETWORK:

Pursuant to section 9767.17(d) of title 8 of the California Code of Regulations, 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 9767.17.5 (Part B)*, which is contained in pages 3 of this form.