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EMPLOYER'S TREATMENT AUTHORIZATION

Date:_____ Time:_____am pm

Patient Name:_____

Employer:_____ Phone #:_____

Fax #:_____ Claim #:_____

Worker's Compensation Insurance Company:_____

Claims Address:_____

Phone #:_____ Fax #:_____

SERVICES REQUESTED:

☐ Injury Treatment Date of Injury:_____ Time of Injury:_____

Injury occurred at (address):_____

☐ Return To Work Evaluation

☐ Preemployment Physical Evaluation

☐ Drug Screening (*Circle one*): Preemployment Random Suspect

☐ Other:_____

Authorized By (*Please Print*):_____

Title:_____

Signature:_____