WORKERS' COMPENSATION
AUTHORIZATION FOR TREATMENT

Patient _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Date of Accident: _____
Address: _____ City: _____ State: _____ Zip: _____

TO THE PATIENT: It is necessary that your employer sign the following Authorization for Treatment and return it to our office.
If not, you will be responsible for payment.

TO THE EMPLOYER: I acknowledge the work-related injury of the above-named patient. You are authorized to render the appropriate care needed for this injury, and we will file the proper forms with our insurance carrier.

Authorized by: _____
Title: _____
Date: _____

PLEASE RETURN THIS FORM IMMEDIATELY TO: Doctor's / Clinic Name _____
Address: _____
City, State, Zip: _____
Telephone: ( ) _____