AUTHORIZATION FOR WORK COMP MEDICAL TREATMENT

THIS SECTION TO BE COMPLETED BY EMPLOYER

Employer Name:_____ Date: _____

Location patient will be treated: _____

Clinic/Hospital:_____

Address:_____

Employee Name:_____ Date of Accident: _____

Employee Job Title:_____ Time of Accident: _____

Employee SS#:_____ Visit Authorized by: _____

Employee Date of Birth:_____ Phone Number: _____

Physician should complete: ☐ Urine Drug Screen Lab Preference: _____

☐ Evidential Breath Test (EBT) ☐ Blood Alcohol only

Describe how injury or illness occurred and part of body involved: _____

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Date of Treatment:_____ Time In:_____ Time Out:_____ ☐ New Injury ☐ Recheck

Diagnostics: ☐ X-rays Taken: _____ ☐ Lab

☐ Urine Drug Screen ☐ EBT ☐ Blood Alcohol ☐ Other:

Impression:_____

Treatment:_____

Rx: _____

☐ May return to work with no limitations: ☐ Today ☐ Next work shift

☐ Unable to return to work

☐ Return to work with the following limitations checked below

In an 8-hour day, an employee can:

	No Restrictions	*Never*	*Occasionally (up to 25%)*	*Frequently (25-50%)*	*Most of the time (up to 75%)*
Stand/Walk	☐	☐	☐	☐	☐
Sit	☐	☐	☐	☐	☐
Bend	☐	☐	☐	☐	☐
Squat	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Overhead reach	☐	☐	☐	☐	☐
Repetitive handtasks	☐	☐	☐	☐	☐
Work above ground or surface level	☐	☐	☐	☐	☐

Other Comments:

☐ No pushing/pulling/lifting over_____lbs. ☐ Do not drive/operate machinery

☐ Wear splint/sling____ days ☐ Keep wound/dressing clean and dry

☐ Physical Therapy Order: _____ ☐ Recheck or Suture Removal Date: _____

Referred to:_____ Date: _____

Attending Physician:_____ Patient Signature: _____

RETURN THIS FORM TO YOUR SUPERVISOR IMMEDIATELY AFTER VISIT

Copy – Physician Copy - Employee