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 hand tasks	☐	☐	☐	☐	☐
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: _____

EMPLOYEE MUST RETURN THIS FORM TO YOUR SUPERVISOR IMMEDIATELY AFTER VISIT