

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 the 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, employee can:

	No Restrictions	Never	Occasionally (up to 25%)	Frequent (25-50%)	Most of the time (up to 75%)	
Stand/Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Repetitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hand Tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Work above ground or surface level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

- | | |
|--|--|
| <input type="checkbox"/> No pushing/pulling/lifting over _____ lbs | <input type="checkbox"/> Do not drive/operate machinery |
| <input type="checkbox"/> Wear sling/sling _____ days | <input type="checkbox"/> Keep wound/dressing clean & dry |

- | | |
|--|---|
| <input type="checkbox"/> Physical Therapy Order: _____ | <input type="checkbox"/> Recheck or Suture Removal Date _____ |
| <input type="checkbox"/> Referred to: _____ | Date: _____ |

Attending Physician: _____ Patient Signature: _____

Employee MUST return this form to your Supervisor Immediately after visit