EMPLOYER'S AUTHORIZATION FOR TREATMENT
(WORKERS' COMPENSATION)

TO: ______________________________ Date ______________

Address ____

This is your authorization to render treatment to the below named employee due to injuries sustained while on the job. (In accordance with the provisions of and under the conditions prescribed by the Workers' Compensation Act.)

Employee ______________________________ Date injured ______________

Address ______________________________ Time injured ______________

Insurance Carrier ______________________________ Policy No. ______________

Address ______________________________ Phone ______________

Agent or Adjuster ______________________________ Phone ______________

Employers name ______________________________ Phone ______________

Address ____

Authorized by ______________________________ Title ______________

PLEASE sign and return this Authorization for Treatment, along with a copy of the completed First Report of Occupational Injury/Illness.

Thanking you for your assistance.

#44

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SAMPLE