WORKER'S COMPENSATION AUTHORIZATION

Patient Name ____

Date of Accident ______________________________________

Disability: Date Last Worked _____________ Date Returned to Work ____________

Employer Name ____
Address ____
____
Phone _________________

Person to Contact ____

Worker's Compensation Carrier
Name ____
Address ____
____
Phone __________________
Person to Contact ____

Do you wish billing to be forwarded to employer or insurance carrier?
Employer
Insurance Carrier

The above patient has advised me of his work-related injury and that he/she is being treated by:
Provider Name ____
Address ____
____
Phone ____

Person to Contact ____

_______________________________________ _________________________
Signature Authorized Representative Date

____
Please Print Name