UrgentCare
New Smyrna Beach | Ormond Beach

AUTHORIZATION FOR TREATMENT OF WORKPLACE INJURY

Employer Name: _____ Contact Name: _____

Employer Address: _____

Employer Phone: _____ Employer Fax: _____

Employee Name: _____ Date of Birth: _____

Claim # or SSN#:_____ Date of Injury:_____

Workers' Compensation Insurer: _____

Insurer's Phone: _____ Policy#: _____

I am the employer for the above-referenced employee/patient, am authorized to execute this form, and responsible for payment for services requested in the event my insurer denies this claim. As such, please provide medical services to the above-mentioned employee for his/her work-related injury as follows (check all that apply):

[ ] Medical and related treatment/procedures/labs for the work-related injury

[ ] 5-Panel drug test Results sent to: _____

[ ] Other:_____

Employer Signature: _____ Date: _____

EMPLOYEE: By signing this form, I certify that the medical facility referenced herein may release medical information related to this evaluation to pertinent parties and that such information may impact my employment.

Employee Signature: _____ Date: _____