



WORK COMP EMPLOYER AUTHORIZED INITIAL VISIT FORM

Date _____ Patient Account # _____

Patient Name _____ DOB _____

Employer Name _____ Date of Injury _____

Insurance Carrier _____

- Authorization for:
- Evaluation Only
 - Evaluation and Treatment
 - Medication Dispensing
 - Drug Testing
 - Durable Medical Equipment Dispensing

Nature of Injury _____

Date of Appointment _____ Physician _____

Name of Authorized Agent (Print) _____

Signature of Authorized Agent _____ Date _____