

MEDICAL SERVICES AUTHORIZATION

COMPANY NAME _____ DATE _____

PATIENT'S NAME _____

- SERVICE(S) REQUESTED
- PHYSICIAN REFERRAL _____
 - PHYSICAL EXAM: TYPE _____
 - WORKERS' COMPENSATION _____
 - LIGHT DUTY AVAILABLE _____
 - RETURN TO WORK EXAM _____
 - URINE DRUG SCREEN: TYPE _____
 - BREATH ALCOHOL TEST _____
 - IMMUNIZATION: TYPE _____
 - OTHER SERVICE _____

AUTHORIZED BY _____ PHONE _____

COMMENTS _____

If a medical problem is deemed to be non-work related, the above individual will be referred to his or her personal physician for further care, but the company will be held financially responsible for this evaluation

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