DynamicHR
Total Human Resource Administration

Authorization for Immediate Medical Treatment

Employer Instructions: Complete this form for your employee to give to your designated medical provider.

Name of Employer:_____

Address:_____

City:_____State:_____ZIP:_____Phone Number:_____

Name of Injured:_____
last *first* *middle*

Date of Injury:_____Place of Injury:_____

Body Part(s) Injured:_____

Description of Accident:

Name of person completing this form:_____Title:_____

Signature:_____Date:_____

Medical Provider:_____Phone:_____

_____
Address *City* *State* *Zip*

To the Medical Provider: This is your authorization to provide medical care to the employee named above. Please treat only injuries related to the accident as described on this form. After treatment, please forward the attending physician's report and all bills to:

Amerisure
PO BOX 1515
Canonsburg, PA
15317