

Workers' Compensation

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:

Dynamic HR
3955 Pinnacle Court
Suite 100
Auburn Hills, MI 48326
Fax: 248-370-0968