Permission to Treat

Employee Information:

Name: _____ Date of Injury: _____
Occupation: _____ Supervisor: _____
Nature of Injury: _____
_____

Employer Information:

Name: _____
Phone Number: _____
Address: _____

Authorization: _____is authorized to treat the above named employee for his/her injury reported to their employer on the date indicated above.

Signature: _____ Date: _____

Physician's Report to Employer

Date Treated: _____ Date of Injury: _____

1. Diagnosis and possible cause: _____
   _____
   _____

2. Is injury related to employment? Yes ( ) No ( ) Doubtful ( )

3. Can injured employee return to work:

   Full Duty status? Yes ( ) No ( ) If no then when? _____

   Modified duty status? Yes ( ) No ( ) If no then when? _____

4. What are your recommendations for treatment? _____
   _____
   _____

5. Please specify any recommendations or limitations in regards to his/her work: _____
   _____

6. Do you expect follow –up treatment? Yes ( ) No ( ) If yes then when and how long? _____
   _____

Attending Physician: _____ Date: _____

Note to Physician: The injured employee is responsible for returning this form to his/her supervisor