

Workers' Compensation Authorization Form



Patient Information

Patient Name _____ Date of Injury _____

Type of Injury _____

Company Information

Company Name _____ Contact Person _____

Company Address _____ Phone # _____

WKC Carrier Name _____ WKC Contact Person _____

WKC Carrier Address _____ Phone # _____

Name of Temporary Agency _____ Temporary Agency Contact Person _____

Temporary Agency Address _____ Phone # _____

Temporary Agency's WKC Carrier Name _____ Temporary Agency's WKC Contact Person _____

Temporary Agency's WKC Carrier Address _____ Phone # _____

File Claim to this Contact (Employer or Carrier)

Is a drug screen required? Yes No If Yes, What Type? _____
Has the employer filled out a 1st Report of Injury? Yes No

This certifies that the above information is correct.
I authorize the medical provider to provide medical treatment to the employee named above.

Signature or Company Authorization Number _____ Date _____

Printed Name _____ Position Title _____

Doctors Care Information

Form Completed By _____ Initials _____

Center _____ Date _____