



6900 E. 47TH AVENUE DR. SUITE 100
 DENVER, CO 80216
 (303) 333-4411 PHONE
 (303) 333-0719 FAX
 WWW.WORKCOMPDOC.NET

Treatment Authorization

Date _____
 Company _____
 Employee Name _____
 Supervisor Name _____
 Supervisor Phone _____
 Date of Injury _____ Time of Injury _____

Check all That Apply:

Medical Treatment: On the Job Injury Off the Job Injury

Return to Work Evaluation:

Physical Examination: DOT New Hire DOT Re-Certification
 Respiratory Physical Other/Specify _____

Drug Screen: DOT Non-DOT Hair Test Stat Test

Breath Alcohol Test: DOT Non-DOT

Reason for Drug and /or Alcohol Testing:

- Pre-Employment Random Follow-Up
 Post Accident Reasonable Suspicion

Add'l Info: _____

Type of Injury (describe complaint): _____

Treatment Authorized By: _____

MEDICAL OFFICE USE ONLY

Verbal Authorization Obtained From: _____

Staff Signature: _____ Date: _____

SEE MAP ON REVERSE



Office Hours

Monday - Friday
 7:00am to 5:00pm

