URGENT CARE+
Care at Your Convenience

www.mylocalurgentcare.net

## Worker's Compensation Authorization

Date: _____

Patient's Name:_____

Patient's Date of Birth: _____

Date of Injury: _____

Employer: _____

Employer's Address: _____

_____

Employer's Phone Number: _____

**PLEASE HAVE THE BELOW INFORMATION COMPLETED IN ITS ENTIRERTY.**

Workers Comp Insurance Carrier's Name: _____

_____

Insurance Carrier's Address: _____

_____

Insurance Carrier's Phone Number: _____

**Insurance Carrier's Fax Number**: _____

Claim number: _____

For initial visit it is ok to not have the claim number yet. If you have one please provide it above.

****** Drug Screen Required?** ☐ **yes** ☐ **no**

**Fax number or email that drug screen results will be sent to.**_____

_____

**I authorize Urgent Care to provide medical treatment to the above injured worker.**

_____ _____

Printed name Signature