Piedmont
OCCUPATIONAL MEDICINE

Workers' Compensation
Authorization for Treatment

In compliance with the Georgia Workers' Compensation law, please complete the following:

Employee: _____ SSN _____

Company/Employer: _____

Address: _____

Telephone: _____ Fax Number: _____

Date of Injury: _____ **Claim Number:** _____

Please briefly describe the injury: _____

_____

Please perform post accident drug screen? YES or NO

Insurance Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

By signing this form, I am authorizing treatment and appropriate injury management by our medical staff for the above patient. Authorization includes phy ician intervention, diagnostic testing, physical therapy and medications if indicated by the treating physician. I understand that it is my ultimate responsibility to notify my insurance carrier of the employee's injury in order to establish a claim under workers' compensation and assure procedures and payment per Georgia's Workers' Compensation Act. If this claim is determined to be a non-work related injury/illness, I also understand that I am responsible for ALL BILLS generated by this claim until I inform Piedmont Occupational Medicine in writing of when the claim is being controverted.

Signed: _____ Printed Name: _____

Date: _____ Title: _____

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