Authority for Treatment

TO: Doctor_____ Date:_____

Patient Name:_____ Date of Birth: _____

Employer: _____ Street Address:_____

Date of Injury: _____ **Nature of Injury:** _____

_____

Instructions/comments: _____

_____

Authorized By: _____

Title: _____

Phone: (____) _____

Date: _____

Billing :

Comprehensive Risk Services
c/o Review Works
21500 Haggerty Road, Suite 250
Northville, MI 48167

DOCTOR: PLEASE SEND EMPLOYEE WITH WRITTEN DISABILITY STATUS AS IT RELATES TO THE ALLEGED WORK INJURY. PLEASE INCLUDE THE DIAGNOSIS AND WHETHER THE EMPLOYEE IS ABLE TO RETURN TO FULL DUTY OR RESTRICTED DUTY WORK. PLEASE DOCUMENT ALL MEDICAL RESTRICTIONS.