AUTHORIZATION FOR MEDICAL TREATMENT & MODIFIED DUTY FORM

Company Name**:** ___________________________________

Employee Name:____________________________________

Date of Injury:______________________________________Time of Injury:_____________________

Insurance Information	**Employee Information**
Contact company contact number above for insurance info	Name & Address

Modified duty will be provided to satisfy all physician's restrictions and or recommendations:

Physician - Please call the contact listed below for further information regarding modified duty available, prior to releasing injured employee.

Contact Name/Number: _______________________________