Downtown Urgent Care| 916 Olive Street| St. Louis, Mo 63101

Phone: (314) 436-9300 Fax: (314) 925-1305

Email address: Webregduc@dhwstl.com

WORKER'S COMP OCCUPATIONAL HEALTH TREATMENT AUTHORIZATION FORM

Employee Name: Today date:

Date of Birth: Employee social security number:

Date of Injury: Type of injury:

Requesting Urine Drug Screen: Y or N Requesting Breath Alcohol Test: Y or N

Employer Name: Phone:

Address: Fax:

Authorized by who: Position of person giving authorization:

Signature:

Name ,Email address, and phone of person who handles work comp cases within the company:

Name:

Email address:

Phone:

THIS INCIDENT HAS ALREADY BEEN REPORTED AND A CLAIM HAS BEEN FILED WITH:**********

Workers Comp Carrier Name:

Address: Phone:

Adjuster Name: Policy Number:

Claim Number:________________________________

****PLEASE NOTE : SHOULD THIS WORKER'S COMP CLAIM BE DENIED BY YOUR W\C CARRIER, WE WILL BILL YOUR COMPANY FOR THE SERVICES PROVIDED TO YOUR EMPLOYEE.****