Medical Service Authorization Form

I \_\_\_Name:( User should come from the system), Position:\_\_(From The system)\_\_\_\_\_\_\_\_\_\_\_\_\_ Company Name (From the system) do herby authorize our employee Name: (From the System) to seek and obtain medical care in the event that our employee need(s) medical care.

Our Company (From the system) agree to be financially responsible for the cost of any medical care provided to this employee.

Our Worker’s Compensation Insurance Carrier is: (From the system)

Policy Number (from the system)

Signature

Date

Position (From the System)

Company Name & Phone Number (From the System)