

## **Authority for Treatment**

TO: Doctor	Date:
Patient Name:	Date of Birth:
Employer:	Street Address:
Date of Injury:	Nature of Injury:
Instructions/comments:	
Authorized By:	Billing:
Title:	Comprehensive Risk Services
Phone: ()	c/o Review Works 21500 Haggerty Road, Suite 250 Northville, MI 48167
Date:	

**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.