CITY OF MONTGOMERY
PHYSICIAN AUTHORIZATION AND TREATMENT REPORT

TO BE COMPLETED BY THE DEPARTMENT:

DEPARTMENT ______________________________ DATE OF INJURY _____________________

EMPLOYEE NAME _______________________________________ SSN ___________________________

EMPLOYEE AUTHORIZED TO SEE DOCTOR ____

DATE ______________________________________ TIME ________________________________

____ _______________________________

AUTHORIZING OFFICIAL DATE

PHYSICIANS

Please complete this AUTHORIZATION AND TREATMENT REPORT and return it to the City of Montgomery via employee or mail.

REFERRALS must be approved by the Workers Compensation Office

LIGHT DUTY assignments must be accompanied with specific restrictions.

CITY OF MONTGOMERY – Risk Management
P.O. Box 1111
Montgomery, AL 36101-1111

Telephone: 334-625-3015

TO BE COMPLETED BY PHYSICIAN:

EMPLOYEE SEEN _______________ OR _______________ ___________________
Office Emergency Room Date

X-RAYS _________________ OR _______________ TAKEN
were were not

DIAGNOSIS: ____

TREATMENT: ____

MEDICATION PRESCRIBED (Types and Amount): ____

EMPLOYEE ________ OR ________ RETURN TO WORK THIS DATE _________ OR _____________
MAY MAY NOT NORMAL LIGHT DUTY

IF LIGHT DUTY, GIVE SPECIFIC RESTRICTIONS ____

____

IF EMPLOYEE CAN'T RETURN, INDICATE DATE EXPECTED TO RETURN:

DATE ____________________ TO NORMAL DUTY ___________________ OR LIGHT DUTY _______________

DATE EMPLOYEE SHOULD RETURN TO DOCTOR_______________________________________

Time In:________
Time Out:_______

____
SIGNATURE OF PHYSICIAN

Supervisor or Department Head Signature Required to Indicate Notification of Work Status: _______________________
Employee must return form to their department by the next business day.