



CareHere!

TREATMENT AUTHORIZATION

Fax Authorization Form to (386) 313-4223

Company Name: Flagler County

Employee Name _____ Date _____

Phone # _____ Department Location _____

Date of Injury _____

Nature of Illness or Injury:

How did injury occur?

Person authorizing treatment _____

Contact Phone _____

CLINIC INFORMATION

1. Describe the incident:

2. What time and date did this occur? _____

3. Did anyone witness the accident? _____

4. How long have you been on job? _____ Is this your regular job? _____

5. Describe your job:

6. How do you feel your job is related to your injury?

7. What other activities are you involved in after work?(bowling, tennis, weight lifting, golf, crafts, farm/gardening, exercise program) How often? When did you last participate?

8. Do you have any other medical problems/previous injury or surgery with this area? Taking any medications presently? Who is your medical doctor? Who is the physician treating you for this problem?