MEDICAL CARE AUTHORIZATION FORM

TO BE COMPLETED BY EMPLOYER: DATE: _____

Injured Employee: _____

Date of Injury: _____Time of Injury: _____

Nature of Injury: _____

Physician: _____ Appt Date: _____

Clinic/Hospital: _____

Address: _____

Authorized Signature: _____ Title: _____

TO BE COMPLETED BY PHYSICIAN:

Diagnosis**:** _____

Treatment: _____

	Return to Regular Duty on: _____
	Return to Modified Duty on: _____
	Restrictions/Limitations: _____
	Unable to Work until: _____

Follow Up appointment set: _____

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and complete.

Physician Signature: _____ Date: _____

SEND ORIGINAL TO:

Claims Administrative Services
Old Glory Insurance Company
P.O. Box 7500
Tyler, TX 75711
Phone: (800) 765-2412
Fax: (903) 509-1888

Retain Copy for your file

Any person who commits workers compensation fraud, upon conviction, shall be guilty of a felony.