AUTHORIZATION FOR MEDICAL TREATMENT FOR WORKERS' COMPENSATION

Drug Screen/Blood Alcohol MUST be Performed for ALL Work Comp Injuries

Provider: _____

Company Name: _____

Employee Name: _____

Date of Injury: _____

Type of Injury: _____

Bill To: **Star HR / Infinity Risk Management**
PO Box 4189
Winter Park FL, 32973 Attn: Claims
claims@irmngt.com

Signature of Supervisor: _____ Date: _____