

AUTHORIZATION FOR MEDICAL TREATMENT FOR WORKERS' COMPENSATION

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

| Provider: | |
|-----------------|--------------------------------------------------------------------------------------------------------------|
| | y Name: |
| Employee Name: | |
| | 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: _____ Date: _____