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** _____

_____ **DATE** _____
AUTHORIZING OFFICIAL

PHYSICIANS

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

REFERRALS must be approved by the Workers' Compensation Office.

LIGHT DUTY assignments must be accompanied with specific restrictions.

CITY OF MONTGOMERY – WORKERS' COMP. **Telephone: 334-241-2015**
P. O. BOX 1111
MONTGOMERY, AL 36101-1111

TO BE COMPLETED BY PHYSICIAN:

EMPLOYEE SEEN _____ OR _____ **DATE** _____
OFFICE **EMERGENCY RM**

X-RAYS _____ OR _____ TAKEN
WERE **WERE NOT**

DIAGNOSIS: _____

TREATMENT: _____

MEDICATION PRESCRIBED (Types & 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 TO WORK, INDICATE DATE EXPECTED TO RETURN:

DATE _____ **TO NORMAL DUTY** _____ **OR LIGHT DUTY** _____

_____
SIGNATURE OF PHYSICIAN