

AUTHORIZATION FOR MEDICAL TREATMENT

NCS Form 006

Date: _____ Job#: _____ Drug Screen Needed: Yes No

Job Name: _____ Location: _____

You may render professional treatment to _____

It is to be understood that the responsibility of the undersigned for the payment of your services is solely that imposed on the employer by the Workers' Compensation Law of the State.

Company: _____

Job Site Address: _____

Signature of a Company Representative Required Prior to Service: _____

RETURN TO WORK NOTICE

Name: _____ Social Security Number ____-____-____

Is able to return to work (date): _____

Is able to return to work with the following restrictions (if transitional duty is needed, give approximate length of time):

Is unable to return to work until (date): _____

Return to Physician (date): _____

Diagnosis: _____

Medications prescribed: _____ (Over The Counter When Possible)

Signature of Physician: _____ Date: _____

Address: _____

**Submit a copy of this form with all Provider Invoices to:
Nitro Construction Services Corporate Safety Department
Fax Number: (304) 204-1350**

Call (304) 204-1500 for information on Insurance Provider in your area/region.