Rev. 4/2024

AUTHORIZATION FOR INITIAL MEDICAL TREATMENT
Department of Energy and Natural Resources

DATE: _____

TO: _____ **ADDRESS:** _____
_____

This form, if signed by our representative and containing all required data, constitutes your authorization to render medical treatment to:

EMPLOYEE: _____ **ADDRESS:** _____
_____

in accordance with the provisions and under the conditions prescribed by the Worker's Compensation Act. Unless the case is an emergency, kindly obtain authorization for surgery, radical procedures or hospitalization from the insurance carrier. **Your bill should be sent to: Office of Risk Management, P. 0. Box 91106, Baton Rouge, Louisiana 70804-9095. They may be contacted at (225) 219-0168.** Following rendition of treatment, please complete the Medical Provider section below and return it to the employee prior to his/her departure or mail to: Safety Coordinator, Department of Energy and Natural Resources, P.O. Box 94396 Baton Rouge LA 70804-9396.

FOR COMPLETION BY DENR'S AUTHORIZED REPRESENTATIVE

DATE OF INJURY: _____

JOB LOCATION: _____

SIGNATURE: _____

FOR COMPLETION BY MEDICAL PROVIDER

NATURE OF INJURY: _____

TREATMENT (CHECK ONE):

_____ Treated, discharged and released to customarily work;
_____ Treated, released to customary duty with follow-up appointment on: _____
_____ Treated, released with restrictions and with follow-up appointment on restriction: _____
_____ Treated, to remain off from work with follow-up appointment on: _____
_____ Admitted to hospital on: _____

IF PATIENT WAS SENT HOME OR ADMITTED TO HOSPITAL, PLEASE ESTIMATE DURATION OF LEAVE NECESSARY: _____

DOCTOR'S SIGNATURE: _____ **DATE:** _____