3440 Declaration Boulevard
Sumter, SC 29150
Phone: (803) 905-FAST
Fax: (803) 905-3282

WORKERS' COMPENSATION AUTHORIZATION

Date: ______________________________

Patient Name: ____

Company Name: ____

Company Address: ____

____

Phone: ____________________________ Fax: ____________________________

Date of Injury: _______________________

Nature of Injury: ____

____

Substance Abuse Testing Required:
Alcohol: Yes ( ) No ( )
Drug Screen: Yes ( ) No ( )

Worker' Compensation Carrier: ____

Incident Report Number: ____

Address: ____

____

Phone: ____

Treatment Authorized By: ____

(Print Name)

Print to Sign: ____

(Signature)

____

(Job Title)

NOTE: Should this Worker's Compensation claim be denied by your W/C carrier, Faster Care will bill your company for the services provided to your employee, As it will be the full responsibility of the employer.

Please Sign Here ________________________________