



City of Georgetown, South Carolina Authorization to Treat**

(To be taken by the Employee/Patient to the Doctor or Emergency Room)

Doctor:

Address:

Please render medical treatment to: Employee/Patient:

Authorized by Supervisor:

Date:

** This authorization is for Initial Treatment Only and payment is guaranteed. Further authorization for testing or treatment must be authorized by our Worker's Compensation administrator:

Companion Third Party Administrators
Post Office Box 11447
Columbia, SC 29211-1447

1-877-825-2477

DOCTOR'S STATEMENT AND RELEASE

To be completed by physician and given to employee/patient. Employee must present this release to the Risk Manager or HR Manager upon completion.

Today, I have treated employee for: _____

Diagnosis (detail injury or condition treated)

Prognosis (estimate future care and recovery time)

Employee is: Released for work Full Duty - No Restrictions
 Released for restricted work (please specify below) ↓

Restrictions:

I Recommend Employee: Return for follow up visit on _____
 Go to specialist: Orthopedic Physical Therapy
 Other: _____

Date: _____ Physician's Signature _____

Print Physician's Name _____