



AFTER HOURS AND WEEKEND

AUTHORIZATION TO PROVIDE MEDICAL TREATMENT

Date: _____

Employee Name: _____

Employer: _____

Contact Name & Phone #: _____

First Treatment Center: _____

.....

Dear Medical Provider,

This employee is being sent to you with a reported work related injury

to: _____

(BODY PART)

- Any non-emergent follow-up care for this injury MUST be referred to the First Treatment Center as noted above.**
- Any work restrictions beyond the next business day and specialist referrals will be determined by the First Treatment Center.**

Bills and medical reports should be forwarded to:

Workers' Compensation Trust
P. O. Box 5042, Wallingford, CT 06492-7542