Richmond County School System
Authorization Form
Employer Notification for Treatment – Work Related Injury

Instructions for completing this form:

1. A copy of this form **MUST** be presented in person to any selected Workers' Compensation medical provider in order to receive medical care.

2. Fax this form to Workers' Compensation 912-355-8929 and take with you to the doctor appointment.

3. An **Employee Accident Form** and any supporting documentation must also be **completed and faxed or emailed** to Workers' Compensation – 912-355-8929

Workers' Compensation doctor selected:

_____ Date of Injury: _____

Describe the Injury:

_____ Body part Injured: _____

Employee Work Location: _____

Employee Name: _____ Date of Birth: ___/___/____

Employee Phone Number: _____

Supervisor Signature: _____

Supervisor Phone Number: _____

Revised: 06/2016