IHC WORKMED Date: _____

Appointment Time: _____

AUTHORIZATION FOR MEDICAL TREATMENT

Employee Name: _____

Company: _____

Supervisor's Name: _____

Telephone: _____

This is to authorize medical treatment to the above named employee for:
PLEASE CIRCLE:

Injury Date of Injury _____
Drug Screen/DOT Non DOT _____
Breath Alcohol
Physical (Type) _____ DOT _____
Other _____

Go To The Following Clinic:

IHC WorkMed
385 N 3050 E
St. George, Utah 84790
(435) 251-2630
Fax: (435) 688-6011
9:00 a.m. until 5:00 p.m.

For 24-Hour Treatment

Dixie Regional Medical Center
544 South 400 East
St. George, Utah 84770
Emergency Department (435) 688-4000