# Worker's Compensation Claim
## AUTHORIZATION FOR INITIAL MEDICAL TREATMENT
**Office of the Lieutenant Governor**
**Department of Culture, Recreation and Tourism**

DATE: _____

TO: _____ ADDRESS: _____

This form, if signed by our representative and containing all required data, constitutes your authorization to render medical treatment to:

EMPLOYEE: _____ ADDRESS: _____

in accordance with the provisions and under the conditions prescribed by the Worker=s Compensation Act. Unless the case is an emergency, kindly obtain authorization for surgery, radical procedures or hospitalization from the insurance carrier. Your bill should be sent to: Office of Risk Management, P. O. Box 90095, Baton Rouge, Louisiana 70804-9095. They may be contacted at **225-342-8521**. Following rendition of treatment, please complete the AMedical Provider@ section below and return it to the employee prior to his/her departure or mail to: Mr. Gerald Ganey, Safety Officer, Office of Lieutenant Governor, Department of Culture, Recreation & Tourism, P. O. Box 94361, Baton Rouge, Louisiana 70804-9361.

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### FOR COMPLETION BY DCRT=S AUTHORIZED REPRESENTATIVE

DATE OF INJURY: _____

JOB LOCATION: _____

SIGNATURE: _____

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### FOR COMPLETION BY MEDICAL PROVIDER

NATURE OF INJURY: _____

TREATMENT (CHECK ONE):

_____ Treated, discharged and released to customary work;
_____ Treated, released to customary duty with follow-up appointment on _____;
_____ Treated, released with restrictions and with follow-up appointment on _____;
Restriction: _____
_____ Treated, to remain off from work with follow-up appointment on _____;
_____ Admitted to hospital

IF PATIENT WAS SENT HOME OR ADMITTED TO HOSPITAL, PLEASE ESTIMATE DURATION

OF LEAVE NECESSARY: _____

DOCTOR=S SIGNATURE: _____ DATE: _____