mend URGENT CARE

TREATMENT AUTHORIZATION

THIS FORM AND A PHOTO ID MUST ACCOMPANY EMPLOYEE AT INITIAL VISIT

BURBANK
1701 W. VERDUGO AVE
BURBANK, CA 91506
TEL: 818.843.8555
FAX: 818.840.7014

VAN NUYS
4849 VAN NUYS BLVD #100
SHERMAN OAKS, CA 91403
TEL; 818.646.4928
FAX: 818.646.2697

SHERMAN OAKS
4312 WOODMAN AVE. #102
SHERMAN OAKS, CA 91423
TEL: 818.646.2562
FAX: 888.509.0185

EMPLOYEE NAME:_____ SSN:_____

COMPANY NAME :_____

ADDRESS:_____

TEL:_____ FAX:_____

AUTHORIZED BY:_____ TITLE:_____

SIGNATURE:_____ DATE:_____

WORK INJURY

WORK INJURY ☐ INJURED BODY PART: DATE OF INJURY: _____

_____ TIME OF INJURY: _____ AM / PM

CURRENT WORKERS COMPENSATION INFORMATION:

INSURANCE NAME:_____ POLICY#:_____

ADDRESS:_____

TEL:_____ FAX:_____