THE GEORGE WASHINGTON UNIVERSITY
AUTHORIZATION FOR MEDICAL TREATMENT

Supervisor to complete:
Employee _____ Date _____
Department _____ Job Title _____
has suffered a work related injury/illness and is authorized to receive treatment at the GWU Emergency Room, 901 23rd Street, N.W. Washington, D.C.

_____
Signature of Supervisor

Attending Physician to Complete:
Nature of injury or illness: _____
Treatment: _____
Disposition (please indicate below):
_____ Return to work
_____ Temporarily disabled from ____ to ____. Estimated fit for duty on ____.
_____ Return to work, limited duty for ____ days. Estimated fit for duty on ____.
_____ Restrictions on work activity: _____
_____ Prescribed medications.
_____ Referred to private physician.
_____ Admitted to the hospital.

_____ _____
Date Signature of Physician

Pharmacy to complete:
Issued the following medications:

_____
_____
_____
_____

_____ _____
Date Signature of Pharmacist

INSTRUCTIONS:

1. Supervisor completes top portion.
2. Employee gives form to treating physician.
3. Employee returns complete form to supervisor.
4. Supervisor sends copy of completed form to the:
   Office of Risk Management
   2025 F Street, NW, Suite 101
   Washington, DC 20052

WORKERS' COMPENSATION INSURANCE CARRIER:

Self-Insured

2002/ORM-3