TRACER
SECURITY SERVICES

MEDICAL TREATMENT AUTHORIZATION	tfor045	REVISION: 5/3/10

The following person is authorized to receive medical treatment.

Last Name: _____ First Name: _____

SSN: _____ Date: _____

Describe Injury or Illness

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Employee Signature

I understand that this authorization does not indicate that this is a work related injury or illness and that pending an investigation of this incident it may be determined that I am personally liable for any and all medical expenses incurred.

Signature: _____ Date: _____

This area to be completed only by Authorized personnel.

Authorized by:

Name: _____ Signature: _____