Workers Comp Medical Service Referral

Employer – complete and sign this form and give to the employee.
Employee- give the completed form to the clinic/physician

Doctor / Clinic Name: _____

Doctor / Clinic Address: _____

We are sending our employee named _____ to you for an evaluation and treatment relative to an injury sustained on the following date: _____

Please note: *We have a transitional return to work program available for the injured employee. All injuries will be considered for modified work duties.*

LWP Claims Solutions

P.O. Box 349016 Sacramento Ca 95834-9016

Phone: (916) 609-3600 Fax: 916-720-0533

Employer Name (Print): _____

Signature: _____

Employer Title: _____

Phone Number: _____