



**Part A - Authorization** > OMB No. 1215-0066

**Instructions to Employer.** This page of the form must be completed in full, and authorizes a physician of the **employee's choice** (\*See item below) to examine and/or treat an employee, covered by the Federal Workers' Compensation Act marked in the box at right, for accidental injury, illness or disease arising out of and in the course of employment.

Mark either box A or B in item 7. The original and at least two copies of this form are to be given to the physician. The physician is to complete the medical report and the initial bill on the reverse, sending within ten days the original of the report to the District Director and copies to the insurance company or employer named in item 13. Subsequent and regular follow-up reports should be submitted by the physician on Form LS-204 and/or in narrative reports, whenever requested.

An employee may not select a physician who is currently not authorized by the Department of Labor to provide medical care under the Act.

- 1. This Authorization is for examination and/or treatment under the Workers' Compensation Act marked below:**
- A Longshore and Harbor Workers' Compensation Act
  - B Defense Base Act
  - C Nonappropriated Fund Instrumentalities Act
  - D Outer Continental Shelf Lands Act

**2. Name and address of physician or medical facility authorized to provide medical service**  
 \* (The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, osteopathic practitioners, and chiropractors. Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, x-rays to diaanose a subluxation of the spine, and treatment consisting of manipulation of the spine to correct a subluxation demonstrated by x-ray. See 20 CFR 702.404)

name: \_\_\_\_\_ city: \_\_\_\_\_ country: \_\_\_\_\_  
 line1: \_\_\_\_\_ st: \_\_\_\_\_ zip: \_\_\_\_\_  
 line2: \_\_\_\_\_

<b>3. Employee's Name</b>	<b>4. Date of Injury (mm/dd/yyyy)</b>	<b>5. Occupation</b>

**6. How accident or illness occurred**

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**7. You are authorized to provide medical services to the employee as follows:**

- A If you believe the condition is related to the iniury. or the employee's occupation, furnish office and/or hospital treatment as necessary for the effects of this injury.
- B If you are in doubt as to whether the condition(s) found on examination is related to the injury, you are authorized to examine the employee, using indicated non-surgical diagnostic studies, and should promptly advise those listed in item 13 whether you believe the disability is due to the alleged injury. Pending further advice you may provide necessary conservative treatment.

**You are requested to submit a written report of first treatment within 10 days to the District Director at the Office named in item 12 below (See back of this form for Instructions as to medical report and the submission of your charges).**

<b>8. Signature and title of authorizing official (Sign all copies)</b>	<b>9. Name and address of employer</b> country: _____
name: _____ title: _____	name: _____ city: _____ line1: _____ st: _____ zip: _____ line2: _____

<b>10. Telephone (Area code and local number)</b>	<b>11. Date authorized (mm/dd/yyyy)</b>

<b>12. Send one copy of your report to:</b>	<b>13. Name and address of insurance carrier or self-insured employer to whom bill and copy of report are to be sent</b>
<b>U.S. Department of Labor                  Employment Standards Administration                  Office of Workers' Compensation Programs</b>	name: _____ city: _____ line1: _____ st: _____ zip: _____ line2: _____ country: _____

**Public Burden Statement**

The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is 20CFR 702.419. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits. According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1215-0066. The time required to complete this information collection is estimated to average 65 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C4315, 200 Constitution Avenue, N.W, Washington, D.C. 20210.

**DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

