1236 Brooks St.

Ontario, CA 91765

Employer Authorization form for Injury – Illness – Disease

- Employer name:
- Employer address:
- Employer phone number:
- Fax number:
- Email address:
- Employer workers compensation insurance name:
- Policy Number:
- ☐Bill employer ☐ Bill Insurance
- This service Authorized By (name):
- Today date:
- Date of Injury:
- Employee's name:
- Date of Birth:
- SS#:
- Employee's address:
- Employees' phone number: