Desert Valley Hospital
Desert Valley Medical Group

JOB RELATED INJURY AUTHORIZATION FORM

Employer: Please complete this priority pass and send it with the employee.

*This pass is to be used by employees to assure that employees sent for medical care are given priority treatment for their job-related injury. The patient should promptly present this pass at the Desert Valley Medical Group reception area.

Date: _____

Employee Name | Social Security # | Date of Birth

Date of Injury | Body Part Authorized for Treatment

Drug Test: YES / NO (circle) Please choose one: ☐ DOT ☐ Non-DOT ☐ Rapid Modified Duty Available YES / NO (circle)

Employer Name

Employer Address | City | Zip

Employer Phone | Fax #

Fax / Email results/status report to: (circle) _____

Authorized by (Print Name): _____

Bill Employer YES / NO (circle) If billing address is different from above, please list it here: _____

Worker's Comp. Insurance Carrier

Worker's Comp. Insurance Address

Adjuster's Name | Phone # | Fax #

Claim Number | Date Filed

Employer Signature/Title _____ Phone # _____

Primary Location:

Occupational Medicine Clinic

12401 Hesperia Road, Suite 9 & 10
Victorville, CA 92395

Phone: 760-245-2474
Fax: 760-241-7416

Hours: 7AM - 7PM
Monday - Friday

After Hours Injury Care:

Desert Valley Medical Group

Urgent Care

16850 Bear Valley Road
Victorville, CA 92395

Phone: 760-241-8000 Ext. 8600
Fax: 760-241-0162

Hours: 8AM - 8PM
Monday - Sunday

Desert Valley Hospital

Emergency Room

16850 Bear Valley Road
Victorville, CA 92395

Phone: 760-241-8000 Ext. 8585
Open 24 Hours a Day