

JOB RELATED INJURY AUTHORIZATION FORM

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

*To expedite service, email form to dvmc-industrialmed@primehealthcare.com or fax to (760) 241-7416.

Date: _____

Employee Name _____ Social Security # _____ Date of Birth _____

Date of Injury _____ Body Part Authorized for Treatment _____

Drug Test: YES / NO Please choose one: DOT Non-DOT Rapid BAT Modified Duty Available YES / NO

Employer Name _____

Employer Address _____ City _____ Zip _____

Employer Phone _____ Fax # _____

Fax / Email results/status report to: _____

Authorized by (Print Name): _____

Bill Employer: YES / NO If billing address is different from above, please list it below:

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 - 5PM
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