Department of Commerce

WORKERS' COMPENSATION COMMISSION
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
P.O. Box 5795 CHRB, Saipan MP 96950
Tel: (670) 664-8018/8024 • Fax (670) 664-8074
Website: www.commerce.gov.mp

WCC FILE #: ______
CARRIER'S #: ______
EMPLOYER'S #: ______

AUTHORIZATION FOR MEDICAL EXAMINATION AND/OR TREATMENT

(To Be Completed By Employer)

INSTRUCTION: *This side should be completed in full. It authorizes a physician (duly qualified physicians include surgeons, osteopathic practitioners, and acupuncturists within the scope of their practice as defined by law) of the employee's choice to examine and/or treat the employee for the injuries arising out of such accidental occupational injury, illness, or disease covered by the CNMI Workers' Compensation Law.*

1. Name of authorized physician	2. Name of Medical Facility:	
3. Physician's Address:	4. Medical Facility's Address:	
5. Name of Injured Employee: S.S. No.: ______ - ______ - ______	6. Occupation:	7. Date of Injury:
8. Description of Injury:		

9. YOU ARE AUTHORIZED TO PROVIDE MEDICAL SERVICES TO THE EMPLOYEE AS FOLLOWS:

☐ If you believe the condition Is related to the Injury, furnish necessary treatment.

☐ If there Is doubt as to whether the condition Is related to the injury, you are authorized to examine the employee, using Indicated non-surgical diagnostics studies, and promptly advise the carrier indicated In Item 14 whether you believe the disability Is due to the alleged Injury. Pending further advice, you may provide such necessary conservative treatment.

☐ Other (Specify)

YOU ARE REQUESTED TO SUBMIT A WRITTEN REPORT OF FIRST TREATMENT WITHIN 20 DAYS TO THE ADMINISTRATOR AT THE ADDRESS INDICATED IN ITEM 13. (See *back of this form for instructions as to medical report and the submission of your* charges). Reports <u>are required</u> if services are to be paid.

10. Signature and title of Authorizing Official	11. Name and Address of Employer:
12. Date:	
13. Send your REPORT to: **CNMI Workers' Compensation Commission** **P.O. Box 5795 CHRB** **Saipan, MP 96950**	14. Name and Address of Insurance Carrier to whom COPY of your REPORT and BILL are to be sent: