MEDICAL SERVICE ORDER

Doctor Name: ______________________________

Address: ______________________________

Employee Name: ____________________ was injured on

______________ (Date) ________ (Time) while in our employ.

Please render necessary medical treatment immediately, then complete and forward the Doctor's First Report Of Occupational Injury Or Illness to:

ACWA/Joint Powers Insurance Authority
PO Box 619082, Roseville CA 95661-9082
(800) 231-5742 FAX (916) 786-0209

Employer: ______________________________

Address: ______________________________

Employer Representative: ______________ Date: ________

One time visit only - call ACWA/JPIA for authorization

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