Treatment to be provided by:

Concentra urgent care

Medical Treatment Referral

(To be completed by Supervisor)

Fax to PMA 800-432-9762

Bills should be sent to:
PMA Customer Service Center, P.O. Box 5231 Janesville, WI 53547-5231 Main Workers' Comp # 888-476-2669

Employer: MEDIC-EMS Agency

Name of Employee: Employee No.: Job Title:

Department: Date of Injury: Time of Injury:

Date Injury Reported: Who Witnessed the Injury?

Vehicle Accident? ○ *Yes* ○ *No* Post-Accident Drug and Alcohol Screening: ○ *Yes* ○ *No*

Was he/she working at their regular job at the time of the accident?

Is medical attention required? ○ *Yes* ○ *No* Emergency: ○ *Yes* ○ *No* Injury location:

Has previous treatment been received for this injury: ○ *Yes* ○ *No* Where:

Describe Incident and Injury:

I believe this event is job related and recommend that this individual seek initial medical care.

Supervisor's Signature: Job Title: Date:

Supervisor's Printed Name: Contact number:

Prescriptions and Driving

To be filled out by the Physician

Prescription Written/Received? *Yes* ☐ *No* ☐

Can the employee safely return to work, while taking this medication? *Yes* ☐ *No* ☐

For Driving Positions: Can the employee currently drive back and forth to work? *Yes* ☐ *No* ☐

Can the employee currently perform his/her driving position? *Yes* ☐ *No* ☐

Physician's Signature: Date: