



**AUTHORIZATION TO TREAT**

**DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**To Hospital/Clinic Staff:** \_\_\_\_\_  
\_\_\_\_\_

Please accept this Letter as your Authorization to Treat our employee for the suspected work-related injury; \_\_\_\_\_.

**EMPLOYEE NAME:** \_\_\_\_\_

Please bill ACCU Staffing Services at:

ACCU Staffing Services  
ATTN: Risk Manager/WC Coord  
911 Kings Highway North  
Cherry Hill, NJ 08034

Phone: **(856) 482-2222, ext 1103**

You may fax invoices and medical reports/work status reports to: **(856) 779-8808.**

- Post-Injury drug screens are absolutely mandatory at the time of initial visit per ACCU company policy. There are no exceptions.
- Alcohol breath tests are given at the request of ACCU staff supervisors or at the discretion of the hospital or clinic staff who may detect possible alcohol intoxication.
- **THE EMPLOYEE WILL ONLY BE TREATED AT THE MEDICAL FACILITY IDENTIFIED IN THIS LETTER OF “AUTHORIZATION TO TREAT”.**
- Any other medical treatment at any other medical facility will be UNAUTHORIZED treatment and payment WILL BE the sole responsibility of the employee.

\_\_\_\_\_  
Person Authorizing Treatment

\_\_\_\_\_  
Branch or On-Site Office

**Thank You for your Kind Treatment of our Employee!**