

To:

From:

Date:

RE: Claimant :
 D/B :
 Soc. Sec. No. :
 Employer :
 D/A :

Please accept this as authorization for initial treatment on the above-captioned injured employee. If this injured worker needs to be referred out, please call FFVA Mutual at 1-800-226-0666.

Please mail your bill and report to FFVA Mutual, P. O. Box 945927, Maitland, Florida 32794-5927; telephone number 1-800-226-0666; fax number (321) 214-0235.

Date: _____

_____ Full Duty

_____ Light Duty (as the employer participates in an Early-Return-to-Work Program)

Restrictions: _____

Diagnosis: _____

Next Office Visit: _____

Please provide the employee with a copy of the completed form.

Thank you for your prompt attention to the above.