Workers' Compensation Treatment Referral **Form WCT**

Farmers Insurance Group

To be completed by Employer: Date:______________

Medical Facility/Doctor:____ Phone:____________

Address:__________________________________ City:____________________ State/Zip:___________

Employee:____SS#______________________

Occupation:___________________________ Date Injury:_____________________ Time:___________

Employer: SOLANO'S INC. Phone: 530-938-3404

Address: 700 Shastina Drive City Weed State/Zip CA 96094

Authorizing Treatment:______________________________________

Instructions to Medical Facility/Doctor:

This authorization is issued to you to provide **initial** medical treatment to the employee named above who has reported an occupational injury.

1. Call the authorizing individual named above immediately if the employee can return to work (full or modified duty).
2. Send original completed doctor's first report to Help Point Claims Services by Farmers:

Mail the first report of injury to:

Farmers WC Imaging Center

PO Box 108843

Oklahoma City, OK 73101-8843

Telephone: 866-967-5256

Fax: 866-846-3114

E-Mail: wcclaimdocs@farmersinsurance.com