WORKERS' COMPENSATION
MEDICAL SERVICE ORDER

TO DOCTOR _____

ADDRESS _____

OUR EMPLOYEE _____
(NAME)

reports an injury to the _____
(PART(S) OF BODY INVOLVED)

while _____
(TELL HOW INJURY OCCURRED)

_____

On _____ At _____
(DATE) (TIME)

Please examine and provide medical treatment which may be required as a result of this injury. Send your "Doctor's First Report of Work Injury" to SEDGWICK with a copy to our Company. Thank you.

ORANGE COUNTY DEPARTMENT OF EDUCATION
200 KALMUS DRIVE, COSTA MESA, CA 92626
(COMPANY NAME AND ADDRESS)

714-966-4059
(PHONE)

_____
(SIGNATURE)

_____
(DATE)

_____
(TITLE)

SEDGWICK
P.O. BOX 619079
ROSEVILLE, CA 95661
(909) 942-4900