



# KAISER ON-THE JOB®

## Occupational Health Treatment Referral Form

Date: \_\_\_\_\_ DOI: \_\_\_\_\_

Employee's Name: \_\_\_\_\_

Employer: **DEPT OF REHABILITATION BUSINESS ENTERPRISES PROGRAM**

Group Number: **CONTRC**

Employer (Vendor) Name: \_\_\_\_\_

Location Number: \_\_\_\_\_

**TPA: STATE COMPENSATION INSURANCE FUND SACRAMENTO CONTRACT OFFICE, P. O. BOX 659011, SACRAMENTO, CA 95865-9011**

WC Phone: **(916) 567-7646 or (916) 567-7511**

**\*\*\*Medical Services Requested\*\*\***

- Work-related Injury/illness
- Other: \_\_\_\_\_

To ensure timely treatment, please call ahead for injury care and drug testing services. Physical Exams are by appointment only.  
\* Northern California Dedicated Occupational Health Centers only.

Employer Signature: \_\_\_\_\_

Contact Name/Title: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Employee Work Hours: from \_\_\_\_\_ am/pm to \_\_\_\_\_ am/pm