CompWest
WORKERS' COMPENSATION WITH CARE™

Employer Medical Service Order

Doctor / Clinic Name:____

Doctor / Clinic Address:____

We are sending ____ to you for an
(Employee Name)

evaluation relative to a work related injury sustained on: ________________________
(Date of Injury)

Please submit your Doctor's First Report of Injury and any subsequent medical reports and bills to:

CompWest Insurance Company
c/o GAB Robins
P.O. Box 370750
Denver CO 80237
Fax: (303) 861-2947
Telephone: (303) 285-2830

Employer Name : _______________________________________

Signature: ____

Print Name and Title: ____________________________________

Phone Number: ____

Please be advised we make every effort to accommodate modified/light duty. Please be specific as to the weight, frequency and duration of those activities.