AF Group AccidentFund UnitedHeartland CompWest ThirdCoast Underwriters

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
PO Box 40790
Lansing, MI 48901
Or fax to: 866-835-5331
Telephone: 714-641-9500 or 888-266-7937

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.