

## 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.**