Capital Area Health Consortium
Residents/Fellows of UConn School of Medicine
For Use By Employee Health or ED
Follow-Up Treatment MUST be in the State of CT

AUTHORIZATION TO PROVIDE MEDICAL TREATMENT

(For Use If Resident Requires Treatment **Outside** Your Facility)

Date: _____

Employee Name: _____

First Treatment Center Location:

- ☐ CCMC
- ☐ HH
- ☐ HFSC
- ☐ HOCC
- ☐ JDH
- ☐ SFH
- ☐ VA
- ☐ OTHER _____

Provider Contact Name & Phone #: _____

Dear Medical Provider,

This employee is being sent to you with a reported work related injury to:

_____
(Body Part)

Any non-emergent follow-up care for this injury MUST be referred to the First Treatment Center as noted above.

Bills should be forwarded to:

Capital Area Health Consortium
270 Farmington Avenue – Suite 352
Farmington, CT 06032
Phone: 860-676-1110
Fax: 860-676-1303