



The UNIVERSITY of OKLAHOMA

Workers' Compensation
Treatment Authorization Form

Norman Campus Employees

Dear Medical Provider:

Please be advised the following employee is authorized to receive initial care for an injury or illness the employee reports having received on-the-job for the University of Oklahoma. The incident will be investigated. This authorization is not an admission of liability or compensability under the Oklahoma Workers' Compensation Act.

Today's Date: _____ Employee: _____

Department: _____ Title: _____

Date of injury: _____ Time of injury: _____

Nature of injury: _____ Body part(s): _____

Authorized by: (please print) _____

Immediate Supervisor or Departmental Manager

Phone Number: _____

Signature: _____

It is the philosophy of the University of Oklahoma to provide modified duty when possible.

Please forward medical treatment reports and/or invoices to OU's Workers' Compensation Administrator, effective July 1, 2006:

Cannon Cochran Management Services, Inc.
1501 North University, Suite 767
Little Rock, AR 72207
Phone: 800-871-5964 (toll-free)
Fax: 501-280-0950

If you have any questions, you may contact the Department of Human Resources on the Norman Campus at: Phone: (405)325-0866 or Fax: (405)325-2435.