



## Authorization for Treatment Form

Patient Name: \_\_\_\_\_ SSN or DOB: \_\_\_\_\_

**Employer: City of Bangor**

**Department: Community Connector**

### **Work Related:**

Injury                      Date of Occurrence: \_\_\_\_\_

### **Post-Offer, Pre-employment Physical:**

- ADA Dispatcher
- Bus Dispatcher
- Bus Superintendent
- Custodial / Janitor
- Lead Transit Driver
- Operator Officer
- Safety and Training Officer
- Transit Driver

Other services/Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Authorized by: \_\_\_\_\_ Date: \_\_\_\_\_

**Have patient hand carry authorization form to the Bangor Concentra being accessed or**

**Email to: [bangorclinic@concentra.com](mailto:bangorclinic@concentra.com)**

**No appointment necessary. Patient must present photo ID at time of service.**

Bangor Concentra  
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(Off Stillwater Ave. Behind Chili's)  
Bangor, ME 04401