



Authorization for Treatment Form

Patient Name: _____ SSN or DOB: _____

Employer: City of Bangor

Department: Public Health and Community Services

Work Related:

☐ Injury Date of Occurrence: _____

Post-Offer, Pre-employment Physical:

☐ Homeless Outreach Caseworker

☐ Housing Support Navigator

☐ Public Health Nurse

Other services/Comments _____

Authorized by: _____ Date: _____

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

Email to: bangorclinic@concentra.com

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

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