Authorization for Treatment Form

Patient Name: _____ SSN or DOB: _____

Employer: City of Bangor **Department: Bangor School Department**

Work Related:

❑Injury Date of Occurrence: _____

Post-Offer, Pre-employment Physical:

❑ School Custodian
❑ Custodial Shift Lead
❑ Utility Custodian
❑ Head Custodian
❑ Food Service Assistant
❑ Food Service Specialist
❑ Food Service Manager
❑ Ed. Tech. (Multi-handicapped Program)
❑ Summer Food Service Manager
❑ High School Cafeteria Manager
❑ Maintenance I
❑ Maintenance II
❑ Maintenance III
❑ Bangor High School Maintenance III
❑ Director of Physical Plant

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