TELEMEDICINE AUTHORIZATION FORM			
First Name	**Last Name**		
Date of Birth	**Injury Date**		
Employer Name			
Employer Address	**City**	**State**	**Zip**
Employer Phone #			
Authorized by	**Authorizer Job Title**		
Please give a contact number for the patient/employee if we need to contact them for a reminder of their telemedicine appointment.			

Appointment Scheduled Date:	**By:**