



**ARCHDIOCESE OF LOS ANGELES  
TREATMENT AUTHORIZATION  
FORM #A.2**

**EMPLOYEE NAME:**

\_\_\_\_\_

**FACILITY NAME:**

\_\_\_\_\_

\_\_\_\_\_

Street Address

\_\_\_\_\_

City

\_\_\_\_\_

State

\_\_\_\_\_

Zip Code

**MEDICAL FACILITY**

\_\_\_\_\_

Name

\_\_\_\_\_

Telephone

\_\_\_\_\_

Street Address

\_\_\_\_\_

City

\_\_\_\_\_

State

\_\_\_\_\_

Zip Code

*You are authorized to pursue initial treatment. If further treatment is necessary, obtain approval from our administrator listed below:*

**Gallagher Bassett Services  
P.O. BOX 70003  
Anaheim, CA 92825 - 0003  
(714) 938-0172**

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

*Facility: Complete this form. Give to employee to present to medical facility and make a copy for employee personnel file.*