FORM STD-29

Authorization of Medical Treatments

Instructions for the Employer: This form authorizes medical treatments for an employee injured at work under the American Samoa Workmen's Compensation Act. The employer must complete this form and provide to the employee to take to the hospital on the date of injury. In case of an emergency, the employer must first take care of the employee and then submit this form directly to the hospital within 2-days from the date of injury. The employer is required to retain a copy for its record and provide a copy to its insurance carrier. An employee is prohibited to use this form to authorize his or her own treatment.

Instructions for the Medical Provider & Treating Physician:

- Upon initial treatments, the employee's primary treating physician is required to furnish and submit to both the employer and carrier an initial medical assessment report on the employee's injury and treatments using FORM ME-01 within 20-days following the first examination or treatment given on such injury. The form can be obtained at the Commission's Office.
- All medical billings must be geared directly to the employer's authorized insurance carrier (or the self-insurer employer).

1. Name of Injured Employee: (First, Middle, Last)	2. Social Security No.:	3. Date of Injury:

4. Sex: ☐ Male | ☐ Female	5. Nationality:	6. Occupation:

7. Name of Employer:	8. Employer's WC Insurance Carrier:

9. Describe briefly the nature of injury:

10. Employer Authorization:

I hereby verify as the employer aforementioned herein authorizes immediate medical treatments for the above injured employee under the American Samoa Workmen's Compensation Act. I fully acknowledge that all related cost incurred by the medical provider for the treatment of the employee's work injury is deemed as the employer's liability and will be charged directly to the self-insurer employer or the employer's worker's compensation insurance carrier for payment, unless an expense or the employee claim is contested and controverted by the employer. I also understand that both the carrier and employer reserve the right to review all billings for payment.

______________________________ | ______________________

Authorized Signature | Date

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Title / Position

FORM DISTRIBUTION:
Original – Hospital (form must be given to the employee) | Copy – Employer | Copy – Carrier