





# Request for Authorization for Prosthetic Services *(continued)*

Worker last name	First name	Middle initial	WorkSafeBC claim number
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**Justification** *(subjective, objective, and justification for repair, replacement, or change)*

**Provider information**

Name of prosthetist	Prosthetist's signature
Name of clinic	
Clinic mailing address/stamp	Clinic payee number
	Clinic telephone number <i>(please include area code)</i>
	Clinic fax number <i>(please include area code)</i>

**WorkSafeBC authorization**

Name of WorkSafeBC officer <i>(please print)</i>	Signature	Date of authorization <i>(yyyy-mm-dd)</i>
Additional comment		