



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	Date of authorization <i>(yyyy-mm-dd)</i>
Additional comment	

Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.