Urgent Care

MEDICAL AUTHORIZATION FORM

DATE: ________________

Send the form with your employee.

EMPLOYEE NAME: _________________________________ **JOB/PO#**____________________

COMPANY NAME:__________________________________ **PHONE#**____________________

COMPANY ADDRESS:_______________________________ **FAX#**______________________

CITY______________________________**STATE**________ **ZIP CODE**__________________

☐ **WORK COMP INJURY**	☐ ☐ **URINE DRUG SCREEN**
☐ Bill Company	☐ DOT (CDL)
☐ Bill workers comp. **insurance carrier**: It is the responsibility of the company to call in a First Report of Injury (Form 1007) to your workers compensation insurance carrier. Please provide carrier info and claim number below.	☐ Non-DOT ☐ DOT Collection ☐ Non-DOT Collection ☐ Quick Screen ☐
Workers Comp. Insurance Carrier Company:________________________ Phone:__________________________ Address:________________________ Adjustor:_____________ City: ______________________ State:________ __________Zip: ____________________	☐ ☐ **ALCOHOL TESTING** DOT Non-DOT ☐ Breath ☐ Saliva ☐ ☐ **REASON FOR TEST** Post Accident Pre-employment Random
Please provide the claim number issued for this Workers Compensation Claim. **Your assistance in providing the claim number for this injury will expedite the management of this injury and the processing of claims. Claim#_______________**	☐ **PHYSICAL EXAMS** ☐ Non-DOT

AUTHORIZED BY:_________________________________***TITLE*:**____________________

(PRINT NAME) (REQUIRED)