

EMPLOYER'S AUTHORIZATION FOR TREATMENT

Date: _____

Patient Name: _____

Date of Birth: _____

Company Name: _____

Date of Injury: _____

Address: _____

<p>Post Accident Substance Abuse Testing:</p> <p>_____ Drug Screen: <input type="checkbox"/> 5 Panel <input type="checkbox"/> 8 Panel <input type="checkbox"/> 10 Panel</p> <p>_____ DOT Regulated Specify Agency</p> <p> <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG</p> <p>_____ Non DOT Regulated</p> <p>_____ Urine Collection Only</p> <p>_____ Blood Alcohol</p>	<p>Physical Examinations</p> <p>_____ DOT Physical</p> <p>_____ Pre-employment</p> <p>_____ Other: _____</p> <p>Drug Testing</p> <p>_____ Blood Alcohol</p> <p>_____ Urine Collection Only</p> <p>_____ Non DOT Urine</p> <p>_____ DOT Urine Specify Agency _____</p> <p><input type="checkbox"/> 5 Panel <input type="checkbox"/> 8 Panel <input type="checkbox"/> 10 Panel</p>
<p>Billing</p> <p>_____ Bill company for services</p> <p>_____ Employee to pay at time of service</p> <p>_____ Bill workers' compensation carrier</p> <p>Carrier: _____</p> <p>Claim #: _____</p> <p>Phone #: _____</p> <p>Address: _____</p> <p>_____</p>	<p>Other</p> <p>_____ TB Test</p> <p>_____ Hep B Vaccine</p> <p> <input type="checkbox"/> Individual <input type="checkbox"/> Series</p>

<u>Employer Authorization</u>	
Authorized By: _____	Title: _____
Phone #: _____	Date / Time: _____

PROFESSIONAL URGENT CARE SERVICES
 640 TYRONE BLVD. N. ST.PETERSBURG, FL 33710
 PHONE: 727-528-7827 FAX: 727-235-0063
 WWW.PROFESSIONALURGENTCARE.COM

