Employer's Authorization Testing and/or Work Injury Treatment Form

(must have photo ID at time of service)

Patient Name:______________________________ SSN/ID#: _______________ DOB: _________

Patient Address: ___________________________________ Patient Phone #: ______________

Company:______________________________________ Co. Phone#: ____________________

Company Address: ____

Company Contact:________________________________ Email: _________________________

Contact: Direct#:____________________ Signature:____________________ Date:____________

Please attach job description if available.

Billing:

______Employer (see address above)
______Employee to pay at time of service
______Workers Compensation (report injury to Ins. Co.)

Ins. Co.______________________________
Address: _____________________________
Phone#: ______________________________
CLM #: ______________________________

Pre-Employment Services: Yes or No

Urine Drug:
___DOT
___Non-DOT Instant Read
___Non-DOT Send to Lab

BAT:
___DOT
___Non-DOT

Work Injury Drug Testing: Yes or No

Urine Drug:
___DOT
___Non-DOT Instant Read
___Non-DOT Send to Lab

BAT:
___DOT
___Non-DOT

Work Related Injury Care:

Date of Injury: _______________

Job Title: ____________________

Description of incident & special instructions: ____

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