EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT

(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

Date: _____

Patient Name: _____ Date of Birth: _____

Company Name: _____ Date of Injury: _____

Office Contact Person: _____

Email For Office Contact:_____ Phone Number_____

Address:_____

WORK-RELATED

___INJURY___ILLNESS

***Post-Accident** Substance Abuse Testing:*

_____ Drug Screen: **[ ]** Urine **[ ]** Hair

[ ] 5 Panel **[ ]** 10 Panel

_____ Urine Collection Only (Employer to provide COC)

TEST TYPE

_____ DOT Regulate _____ Non-Regulated

BILLING

_____ Bill Company for Services *

_____ Employee to pay at time of service

_____ Bill Workers' Compensation Carrier

Carrier: _____

Claim#: _____

Phone #: _____

Address: _____

PHYSICAL EXAMINATIONS

_____ DOT Physical **[ ]** New **[ ]** Recertification

_____ Pre-employment

_____ Return to Work Physical

_____ Other:_____

DRUG & ALCOHOL TESTING

Reason for Test:

[ ] Pre-Employment **[ ] Random** **[ ] Post-Accident**

[ ] Reasonable Suspicion **[ ] Other:** _____

_____ DOT Urine

_____ Non-DOT Urine **[ ]** 5 Panel **[ ]** 10 Panel

_____ Urine Collection Only (Employer to provide COC)

_____ Hair Collection Only (Employer to provide COC)

OTHER:

_____ TB Test _____ CxR Other: _____

EMPLOYER AUTHORIZATION (Authorization for services is valid for 24 hours from the date and time it was signed)

Authorized By: _____ Title: _____

Phone #: _____ Date / Time: _____

***(Only if Company has a "Direct Bill Agreement" signed and on file with Pronto Urgent Care)**

FOR PRONTO URGENT CARE USE ONLY [ ] Yes Obtained consent for treatment

Signature: _____ Date / Time: _____

2500 E. Commercial Blvd. Suite D. - Fort Lauderdale, Florida 33308

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