

Statesboro Urgent Care
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: _____
 Address / Location#: _____

WORK-RELATED **INJURY** / **ILLNESS**

Post Accident Substance Abuse Testing:

Drug Screen [] Urine [] Hair
 Breath Alcohol
 Urine Collection Only

TEST TYPE

DOT Regulated
 Non-Regulated

PHYSICAL EXAMINATIONS

Job Title: _____
 DOT physical
 Pre-employment / return to work
 Other: _____

DRUG TESTING

Breath Alcohol
 Hair Collection
 DOT Urine
 Non DOT Urine
 Urine Collection Only

BILLING

Bill Company for services (excludes Work Comp)
 Employee to pay at time of service
 Bill Workers' Compensation Carrier
 Carrier: _____
 Claim#: _____
 Phone #: _____
 Address: _____

NOTES

Authorized By: _____
 Phone #: _____
 [] Yes Obtained consent for treatment

Title: _____
 Date / Time: _____
 Signature: _____
 Date / Time: _____

