STATESBORO URGENT CARE

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

BILLING

_____ Bill Company for services (excludes Work Comp)

_____ Employee to pay at time of service

_____ Bill Workers' Compensation Carrier

Carrier: _____

Claim#: _____

Phone #: _____

Address: _____

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

NOTES

Authorized By: _____ Title: _____

Phone #: _____ Date / Time: _____

[ ] Yes Obtained consent for treatment Signature: _____

Date / Time: _____

Fax: (912) 225-5719

Phone (912) 259-9474
Address: 1176 Brampton Avenue, Statesboro, GA 30458