NextCare® URGENT CARE

# Authorization For Services

**Employee Name** _____

**Company Name** _____ **DOB** _____

**Company Address** _____

_____

_____

_____

**Company Telephone** *Primary Contact:* _____

*Secondary Contact:*

## MEDICAL TREATMENT

- ☐ Work-Related Injury/Illness
- ☐ Return to Work Evaluation
- ☐ Non-Work-Related Injury/Illness

**Post-Accident Testing:**

- ◯ Drug Screen
- ◯ Breath Alcohol

### DRUG SCREEN

- ☐ DOT
- ☐ Non-DOT
- ☐ Rapid

- ◯ Pre-Employment
- ◯ Post-Accident
- ◯ Random
- ◯ Reasonable Suspicion

### PHYSICAL EXAMINATION

- ☐ Basic Pre-placement
- ☐ DOT
- ☐ Company Specific
- ☐ Other (please specify):

### OTHER TESTING

- ☐ Audiometric
- ☐ Breath Alcohol
- ☐ EKG
- ☐ Spirometry (PFT)
- ☐ TB Testing
- ☐ Other (please specify):

### INJURY - TYPE & LOCATION

_____

_____

_____

_____

_____

### WORKERS' COMP. INFO:

**CARRIER:** _____

**POLICY #:** _____

**ADDRESS:** _____

_____

**PHONE:** _____

_____

### OTHER INSTRUCTONS:

### COMMENTS:

_____

_____

_____

_____

_____

_____

**AUTHORIZED BY:** _____ **DATE:** _____

**TITLE:** _____ **PHONE:** _____