Rincon Medical Urgent Care Center-Worker's Compensation

AUTHORIZATION FOR EXAMINATION OR TREATMENT

Employee Name_____ S.S.#_____DOB_____/_____/_____

Employer:_____Contact Name_____

Billing Address for Claim

_____

Work Related

☐ Injury/Accident ☐ Illness Date of Injury/Accident/ Illness

_____/_____/_____

Describe Injury/Accident/ Illness _____

_____

_____

Substance Abuse Test (check all that apply)

☐ 5 Panel Quick Screen ☐ 11 Panel Quick Screen

Substance Abuse Testing Type

☐ Pre-Placement ☐ Reasonable ☐ Cause Post Accident

☐ Random ☐ Periodic ☐ Follow-up

Physical Examination

☐ Pre-placement ☐ Annual ☐ Fitness for Duty

DOT Physical Examination

☐ Pre-Placement ☐ Recertification

Special Instruction/ Comments_____

Authorized By:_____

Print_____

Date_____/_____/_____ Phone Number ( )

_____

Fax # for test Results ( )_____

119 Chimney Road, Rincon Georgia 31326 Office 912-295-5560 Fax 912-295-5562

Open 7 Days A Week Mon-Fri 8am-8pm Sat-Sun 9am-5pm