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 ____

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Substance Abuse Test (check all that apply)

☐ Drug Test Not Required ☐ 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

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 9am-7pm Sat-Sun 9am-3pm