



Mountain Medical Urgent Care

OCCUPATIONAL HEALTH

Personally Identifiable Information

Patient Name:

Date of Birth:

Social Security Number:

Phone Number:

Drivers License/Passport/Photo ID #:

Employer Name:

If this is an unauthorized charge for a company, this will become donor's responsibility. Results of the test are the property of the company; you can obtain a copy through your company only. I authorize the results of this test to be released to my aboved named employer.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

Employer Name:

Account #:

Amount Paid:

Payment Method: Cash Check Visa

Date:

Time:

Witness:

- Authorization Form**
- Drug Screen
- Breath Alcohol
- Directly Observed
- Other Services:

Charged out By: _____ On: _____ OK to File By: _____ On: _____

Sent/Resulted out By: _____ On: _____

Method: