

AUTHORIZATION FOR TREATMENT OF WORKER

DATE _____ TIME _____

EMPLOYEE'S NAME _____

EMPLOYER NAME _____

MAILING ADDRESS _____

PHONE _____ FAX _____ CONTACT _____

WHO WILL BE RESPONSIBLE FOR PAYMENT? PLEASE CIRCLE ONE

EMPLOYER WORK COMP SELF/PATIENT

PLEASE PROVIDE THE FOLLOWING SERVICES TO EMPLOYEE:

_____ WORK COMP EVALUATION & TREATMENT

_____ OCCUPATIONAL HEALTH SERVICES:

_____ AUDIOMETRIC TESTING

_____ BLOOD ALCOHOL TEST

_____ BREATH ALCOHOL TEST

_____ COLLECTION ONLY DRUG SCREEN

_____ DOT

_____ HRS

_____ 5-PANEL

_____ 8-PANEL

_____ 10-PANEL

_____ RAPID DRUG CARD

_____ EKG

_____ EXAMS

_____ ANNUAL

_____ DOT

_____ PRE-PLACEMENT

_____ RESPIRATORY

_____ FITNESS FOR DUTY

_____ HEPATITIS INJECTION (A OR B)

_____ LAB SERVICES (CIRCLE)

_____ CBC

_____ LIPIDS

_____ CMP

_____ HBS AG

_____ HBS AB (QUANT)

_____ HCV

_____ HIV

_____ UA

_____ HEAVY METAL SCREENING

_____ OTHER _____

_____ P.P.D. (T.B. TEST)

_____ PULMONARY FUNCTION

_____ TETANUS INJECTION

_____ X-RAY (CIRCLE)

CHEST X-RAY 1 VIEW

CHEST X-RAY 2 VIEW

_____ OTHER _____

TO BE COMPLETED BY EMPLOYER

W/C INSURANCE COMPANY NAME _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

ADJUSTOR NAME _____ PHONE _____

CLAIM NUMBER _____ DATE OF INJURY _____

Leesburg

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