

TREATMENT AUTHORIZATION

We are authorizing the below listed U.S. HealthWorks location to provide services to our employees:

U.S. HEALTHWORKS MEDICAL GROUP LOCATED AT:

ADDRESS: _____

PHONE: _____

FAX: _____

EMPLOYER NAME: _____ EMPLOYER# (if applicable): _____

EMPLOYER ADDRESS: _____ PRIMARY CONTACT NAME: _____

PH: _____ PH (after HRs/Cell): _____

FAX: _____ EMAIL: _____

EMPLOYEE DETAILS

DATE: _____ TIME: _____ AM OR _____ PM

PATIENT NAME: _____ DEPARTMENT: _____

DOES EMPLOYEE WORK FOR A TEMP/LEASING COMPANY? YES NO NAME OF TEMP AGENCY: _____

AUTHORIZED BY: NAME (PRINT): _____ PHONE: _____

TITLE: _____ AFTER HRS / CELL PH: _____

SIGNATURE: _____ () VERBAL

INSURANCE

INSURANCE COMPANY NAME: _____

CLAIMS ADDRESS: _____

PHONE#: _____ EFFECTIVE DATE: _____

POLICY #: _____ EXPIRATION DATE: _____

SERVICES

INJURY: DATE OF INJURY: _____ LAST WORKED: _____

INJURED BODY PART: _____ CLAIM #: _____

RETURN-TO-WORK EVALUATION

PHYSICAL EXAM TYPE: _____ PROTOCOL #: _____

DRUG/ALCOHOL TEST. SPECIFY TYPE AND REASON/PURPOSE BELOW

TYPE:

- INSTANT DRUG TEST NON-DOT BREATH ALCOHOL TEST
 NON-DOT DRUG TEST DOT BREATH ALCOHOL TEST
 DOT DRUG TEST

(CIRCLE BRANCH: FMCSA FAA FTA FRA PHMSA USCG)

PROTOCOL # _____

REASON/PURPOSE:

- POST-OFFER REASONABLE SUSPICION
 POST-ACCIDENT RANDOM
 RETURN TO DUTY POST-INJURY

NOTE: PICTURE ID REQUIRED FOR DRUG TESTING

Thank you for choosing U.S. HealthWorks Medical Group!