Employer's Authorization for Treatment

This form must be completed before treatment can be provided and is required for an employer related visit. Patient picture ID required.

Date ______________ Patient/Employee Name ________________________________ DOB _________________

Company Name ____

Company Contact _____________________________________ Title ___________________________________

Company Phone ______________________ Fax _________________ Email __________________________

Company Address ____

City ____ State ___________ Zip ________________

PLEASE COMPLETE FOR ALL WORKERS COMPENSATION CLAIMS:

Has Employer filled out First Report of Injury? ___ Yes ___ No *(send/attach copy if available)*
Where are claims to be filed? ___ Employer ___ Carrier ___ Billing Company
Carrier ________________________________ Phone ____________________ Policy # _____________
Address ______________________________ City ______________________ State ______ Zip _____

Workers Compensation Injury:
Date of Injury ___________________________________ Injury Site ______________________________________
Type of Injury ___________________________________ Claim # ____________________________________
Authorized to dispense medicine __Yes __No

SERVICES REQUESTED:
___ DOT

DOT - Specify DOT Agency ___ FMCSA ___ FAA ___ FRA ___ FTA ___ PHMSA ___ USCG
Specify Testing Authority ___ HHS ___ NRC

___ Non-DOT
Physical Examination
___ Physical Pre-Employment
___ Respiratory Clearance PE
___ Other Physical *(please indicate)* ____

___ Post-Accident Drug Screen Required ____ Random ___ Other

Drug Screen/Testing

___ Lab Corp ___ Quest

Urine:
___ 5 Panel
___ 9 Panel
___ 10 Panel

Results:
___ Instant
___ Send Out
___ Other (*please specify)* _____________________

Special Examinations

___ Audiogram
___ Chest X-Ray
___ Hepatitis B Profile
___ PPD (TB Test)
___ Blood Lead Level
___ Hepatitis B Immunization
___ Spirometry (with Letter)
___ Tetanus Shot
___ Flu Shot

___ **Breath/Blood Alcohol** ___ **Hair Sample** ___ **Saliva Testing**

Other (*please specify)* ____

AUTHORIZED BY: *We (Employer) are authorizing AppleCare to provide treatment to employee. By doing so, we acknowledge that we are responsible for payment of any/all services in the event a claim is not filed and paid in our behalf.*

Name _____________________________________ Signature ______________________________________