



1208 US HWY 98
Daphne, AL 36526
Phone: 251.626.5377
Fax: 251-621-8260

Authorization for Medical Treatment (Required)

Employer – Please complete and fax authorization to our office

Employee Name _____ DOB _____

Occupation _____

Worker’s Comp? Yes _____ No _____ Date & Time Injured _____

CHECK ALL SERVICES THAT ARE AUTHORIZED FOR THIS VISIT:

Physical Exam Yes _____ No _____

CHECK ONE: DOT Regulated _____ or Non-DOT Regulated _____

Post Injury Treatment Yes _____ No _____ (**Is a drug-screen required at this visit?)

Reason: **Post-Accident _____ Pre-Employment _____ Random _____ Other _____

****Urine Drug Screen:** Yes _____ No _____
(Your Chain of Custody Form Will Be Required If We Are Not Your MRO)

Rapid YES _____ NO _____ 5 panel _____ 10 panel _____

Breath Alcohol Screen: Yes _____ No _____

Additional Services Required: _____

MUST BE COMPLETED BY THE COMPANY:

Company Name _____

Billing Address: _____

Supervisor _____ Telephone _____

After Hours Contact _____ Telephone _____

Additional Services Required _____

Send Results to: _____

Fax: _____ or Email _____

Authorized Signature: _____ Date: _____

Print Name: _____