St. Joseph's/Candler Immediate Care | South Georgia Immediate Care Center

GEORGIA EMERGENCY ASSOCIATES IMMEDIATE CARE CENTERS

# EMPLOYER'S AUTHORIZATION
## FOR EXAMINATION and/or TREATMENT

**Employer** must complete this form prior to the employee visit. **Employee** must present photo ID at time of service.

| | |
|---|---|
| Employer Company Name | |
| Patient Name | Patient SSN/ID# |
| Employer Physical Address | |
| Employer Billing Address | |
| Employer PRIMARY Contact Name | Employer PRIMARY Contact Title |
| Employer PRIMARY Work Phone | Employer PRIMARY Mobile Phone |
| Employer PRIMARY Contact E-Mail | Employer PRIMARY Contact Fax |
| Employer PRIMARY Contact Best contact: ☐ Work Phone ☐ Mobile Phone ☐ E-mail ☐ Fax ☐ Other: | |
| Employer DER Name: | Employer DER Best Contact: |
| Authorization Signature | Visit Date |

### BILLING INFORMATION

☐ Bill EMPLOYER (see Employer Billing Address above)

☐ EMPLOYEE to pay at time of Service

☐ Bill WORKERS' COMPENSATION Insurance Company / TPA*:

Ins. Co. _____

Policy # _____

Address _____

Phone _____

Contact _____

Claim # _____

### WORK-RELATED INJURY CARE

Date of Injury: _____

☐ Evaluate and Treat ☐ Light Duty is Available

Be sure to indicate Drug Screen and/or Breath Alcohol Test required under *DRUG and ALCOHOL TESTING SERVICES*

Are Drug Screens and/or Breath Alcohol Tests covered by Workers' Comp Ins Co/TPA?

☐ Y ☐ N ☐ N/A

### REPORTING RESULTS

☐ Fax paperwork to employer

☐ E-mail paperwork to employer

☐ Call employer

☐ Give all paperwork to employee

☐ Give DOT card/Instant Screen Results Card only

**SPECIAL INSTRUCTIONS**

_____

_____

### DRUG and ALCOHOL TESTING SERVICES

REASON FOR TESTING:

☐ Post-Accident ☐ Random

☐ Pre-employment ☐ Reasonable Suspicion

☐ DOT New Certification ☐ DOT Recertification

TEST REQUIRED:

☐ DOT Drug Screen ☐ Hair Follicle Testing

☐ 5-Panel Urine Screen ☐ Specimen Collection only

☐ Instant ☐ Breath Alcohol Test

☐ Lab-based

☐ 10-Panel Urine Screen

☐ Instant

☐ Lab-based

### OCCUPATIONAL MEDICAL SERVICES

☐ DOT Physical – New Certification

☐ DOT Physical – Recertification

☐ Non-DOT Physical (Standard)

☐ Non-DOT Physical (Employer Provided)

☐ Fit For Duty Evalutaion (Physical + PPE)

Job Title/Desc _____

☐ Audiogram

☐ Pulmonary Function Test (PFT)

☐ Chest X-Ray

☐ Lumbar Spine X-Ray

☐ EKG

☐ TB Test

☐ Nicotine Test

☐ Flu Shot

☐ Hepatitis Vaccine (circle) A B Both

☐ Other _____