NextCare®
URGENT CARE

# Authorization For Services

**Employee Name** ______________________________

**Company Name** ______________________ **DOB** ______________

**Company Address** ______________________________

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**Company Telephone** *Primary Contact:* ______________________

*Secondary Contact:* ______________________

## MEDICAL TREATMENT

- ☐ Work-Related Injury/Illness
- ☐ Return to Work Evaluation
- ☐ Non-Work-Related Injury/Illness

**Post-Accident Testing:**

- ◯ Drug Screen
- ◯ Breath Alcohol

## DRUG SCREEN

- ☐ DOT
- ☐ Non-DOT
- ☐ Rapid

- ◯ Pre-Employment
- ◯ Post-Accident
- ◯ Random
- ◯ Reasonable Suspicion

## PHYSICAL EXAMINATION

- ☐ Basic Pre-placement
- ☐ DOT
- ☐ Company Specific
- ☐ Other (please specify):

## OTHER TESTING

- ☐ Audiometric
- ☐ Breath Alcohol
- ☐ EKG
- ☐ Spirometry (PFT)
- ☐ TB Testing
- ☐ Other (please specify):

## INJURY - TYPE & LOCATION

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## WORKERS' COMP. INFO:

**CARRIER:** ______________________

**POLICY #:** ______________________

**ADDRESS:** ______________________

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**PHONE:** ______________________

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## OTHER INSTRUCTONS:

## COMMENTS:

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**AUTHORIZED BY:** ______________________ **DATE:** ______________

**TITLE:** ______________________ **PHONE:** ______________