



TREATMENT AUTHORIZATION FORM

Date:	Time:
Patient Name:	Supervisor Telephone:
Employer Name:	Authorized by:
Work Comp. Insurance:	Title:

<input type="checkbox"/> TREATMENT OF INJURY		
Date of Injury: _____ Time of Injury: _____		
Injured Body Part: _____		
<input type="checkbox"/> PHYSICIAN TO DETERMINE IF ALLEGED INJURY IS WORK RELATED?		
<input type="checkbox"/> PHYSICAL EXAM		
<input type="checkbox"/> DMV/DOT PHYSICAL	<input type="checkbox"/> BACK EVALUATION	
<input type="checkbox"/> PRE OR POST EMPLOYMENT PHYSICAL	<input type="checkbox"/> SPIROMETRY	
<input type="checkbox"/> RETURN TO WORK	<input type="checkbox"/> OTHER: _____	
<input type="checkbox"/> DRUG SCREEN / ALCOHOL TESTING (PICTURE ID REQUIRED)		
<input type="checkbox"/> PRE / POST OFFER EMPLOYMENT	<input type="checkbox"/> POST ACCIDENT	
<input type="checkbox"/> RANDOM	<input type="checkbox"/> REASONABLE SUSPICION	
<input type="checkbox"/> DRUG TEST	<input type="checkbox"/> BREATH ALCOHOL TEST	<input type="checkbox"/> HAIR
<input type="checkbox"/> DOT	<input type="checkbox"/> DOT (BAT)	<input type="checkbox"/> DOT
<input type="checkbox"/> NON-DOT	<input type="checkbox"/> NON-DOT (BAT)	<input type="checkbox"/> NON-DOT
		<input type="checkbox"/> OTHER: _____

HOURS
Monday through Friday (8am through 6pm)
After Hour Injuries (available 24 hours / 7 Days a week)

FOR AFTER HOUR INJURIES CALL
(909) 319-8780



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