Treatment Authorization Form

Company Name: _____
Employee Name: _____
SSN: _ _ _ - _ _ - _ _ _ _ **Phone :** _ _ _ - _ _ _-_ _ _ _ **Date:** _ _ / _ _ / _ _ _ _

Check the Appropriate Service for Employee Treatment:			**Reason for Test:**
___ Physical Exam	___ DOT	___ Non-DOT	___ Pre-Employment
___ Breath Alcohol	___ DOT	___ Non- DOT	___ Random
___ Drug Screen	___ DOT	___ Non-DOT	___ Post-Accident
___ TB Test			___ Reasonable Susp.
___ PFT			___ Return to Duty
___ X-Ray			___ Other
___ Injury Treatment			_____

Please describe your injury or service requested: _____
_____
_____
_____
_____

Charges to be paid by: **___ Employer ___ Employee**

I authorize Emergicare of Harrisonburg, Inc. to conduct the services marked above and to report results to my employer through the company's appointed medical review office.

_____ _____
Employee Signature Signature of Person authorizing service

EmergiCare of Harrisonburg
182 Neff Avenue Suite W12
Phone: 540-432-9996
Fax: 540-432-9997
Hours: M-F: 8am-3pm Sat: 9am-2pm