Treatment Authorization Form

Company Name:_____

Employee Name:_____

SSN:__ __ __-__ __-__ __ __ __ **Phone:**__ __ __-__ __ __-__ __ __ __ **Date:**__ __/__ __/__ __ __ __

Check the Appropriate Service for Employee Treatment:			**Reason for Service:**
____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 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 Services

Emergicare of Harrisonburg, Inc
343 Neff Ave Suite C
Harrisonburg, Va 22801
Ph: (540)432-9996
Fx: (540)432-9997