

Treatment Authorization Form

Company Name: _____		
Employee Name: _____		
SSN: _____ - _____ - _____	Phone: _____ - _____ - _____	Date: ____/____/____

Check the Appropriate Service for Employee Treatment:			Reason for Service:
<input type="checkbox"/> Physical Exam	<input type="checkbox"/> DOT	<input type="checkbox"/> Non-DOT	<input type="checkbox"/> Pre-Employment
<input type="checkbox"/> Breath Alcohol	<input type="checkbox"/> DOT	<input type="checkbox"/> Non-DOT	<input type="checkbox"/> Random
<input type="checkbox"/> Drug Screen	<input type="checkbox"/> DOT	<input type="checkbox"/> Non-DOT	<input type="checkbox"/> Post-Accident
<input type="checkbox"/> TB Test			<input type="checkbox"/> Reasonable Susp.
<input type="checkbox"/> PFT			<input type="checkbox"/> Return to Duty
<input type="checkbox"/> X-RAY			<input type="checkbox"/> Other
<input type="checkbox"/> 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.
755A Martin Luther King Jr Way.
Harrisonburg, VA 22801
Phone: 540-432-9996
Fax: 540-432-9997