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Department of Workers Compensation

AUTHORIZATION FOR TREATMENT FORM

Company Name: _____

Employee Name: _____

Position / Job Title: _____

PLEASE CHECK ALL ITEMS AND PROCEDURES THAT YOU REQUIRE FOR YOUR EMPLOYEE.

WORKER'S COMPENSATION

- Post Accident/Injury Drug Screen
- Modified Duties Available
- No Modified Duties Available

EMPLOYMENT EXAMS

- | | | |
|--|--|--|
| <input type="checkbox"/> Basic Physical Exam | <input type="checkbox"/> Rapid 5-Panel Drug Screen | <input type="checkbox"/> DOT Breath Alcohol Test |
| <input type="checkbox"/> DMV/DOT Physical Exam | <input type="checkbox"/> Non-DOT Drug Screen | <input type="checkbox"/> TB/PPD Skin Test |
| <input type="checkbox"/> Range of Motion / Back Exam | <input type="checkbox"/> DOT Drug Screen | <input type="checkbox"/> Spirometry/PFT |
| <input type="checkbox"/> Back X-Ray | <input type="checkbox"/> Hair Follicle Collection | <input type="checkbox"/> Chest X-Ray |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Non-DOT Breath Alcohol Test | <input type="checkbox"/> Hepatitis B Series |
| | | <input type="checkbox"/> Audiogram |

REPORT RESULTS TO:

(First Name, Last Name)

Report Results via:

- Fax: _____
- Phone: _____
- Mail Results to: _____

Special Instructions: _____

Authorized Representative Signature

Date