



Temecula
24 Hour Urgent Care
We're here when you need us.
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Carlsbad
Urgent Care
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2804 Roosevelt Street, Carlsbad, CA 92008
Ph: 760.720.2804 | Fax: 760.720.7400
www.carlsbadurgentcare.com



Carlsbad Urgent Care
San Marcos
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AUTHORIZATION FOR TREATMENT FORM
DEPARTMENT OF OCCUPATIONAL HEALTH
DEPARTMENT OF WORKERS' COMPENSATION

Company Name: _____
Employee Name: _____
Position / Job Title: _____

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

OCCUPATIONAL HEALTH / PRE-EMPLOYMENT EXAMS ****NOTE:** Photo I.D. required for all drug screens and Breath Alcohol Tests.

Type of PHYSICAL EXAM:

DOT / DMV Physical Exam
 BASIC Physical Exam

OTHER SERVICES:

Audiogram
 Back X-Ray
 Chest X-Ray
 EKG
 Hep. B Titer / Series (if not immune)
 MMR Titer / Vaccine
 Range of Motion / Back Exam
 Spirometry / PFT
 TB / PPD Skin Test
 Varicella Titer / Vaccine

SELECT TYPE/S OF DRUG SCREEN/S:
CHECK ALL THAT ARE APPLICABLE.

Drug Screens Below are SENT TO LABS for results.	Check Below for IN-HOUSE Drug Screens:
<input type="checkbox"/> DOT Drug Screen	<input type="checkbox"/> Rapid 5-Panel Screen
<input type="checkbox"/> Non-DOT Drug Screen	<input type="checkbox"/> Rapid 9-Panel Screen
<input type="checkbox"/> Hair Follicle Collection	<input type="checkbox"/> Rapid 10-Panel Screen

CHECK ALL THAT ARE APPLICABLE FOR DRUG SCREEN:

OBSERVED Drug Screen PRE-EMPLOYMENT Post-Accident (*No Injury*)
 RANDOM Drug Screen RETURN TO DUTY Reasonable Suspicion
 FOLLOW-UP _____

Type of BREATH ALCOHOL TEST:

DOT Non-DOT

WORKERS' COMPENSATION ****NOTE:** Photo I.D. required for all drug screens and Breath Alcohol Tests.

Post-Injury PROTOCOLS:
(Check All That Apply):

Restricted Duties Available
 Modified Duties Available
 No Modified Duties Available
 Follow Employer's Protocol
 File **WC INSURANCE**
 Use **WC Credit Card on File**
 Treat **AS FIRST AID** if possible

Post-Injury DRUG SCREEN:
(Check All That Apply):

Required Not Required

SELECT TYPE/S OF DRUG SCREEN/S:

DOT Drug Screen
 Non-DOT Drug Screen
 Hair Follicle Collection

Check Below for **IN-HOUSE** Drug Screens:

Rapid 5-Panel Screen
 Rapid 9-Panel Screen
 Rapid 10-Panel Screen

Check Below if **Applicable:**

OBSERVED Drug Screen

Post-Injury BREATH ALCOHOL TEST:

Required Not Required

Type of BREATH ALCOHOL TEST:

DOT Non-DOT

REPORT RESULTS TO:

(Contact First & Last Name) _____ (Position / Title) _____

Report Results via: (Check all that apply.) Fax: _____ Phone: _____
 Mail / Email: _____

Signature of Authorized Representative's Signature _____ Date _____
Printed Name of Authorized Representative: _____