



URGENT CARE

BUFFALO GAP
4424 Buffalo Gap Rd
Abilene, Tx 79606
Phone: (325) 999-9685 Fax: (325) 690-6160

AUTHORIZATION FORM

Send the form with your employee or **fax** it to: (325) 690-6160 **DATE:** _____

EMPLOYEE NAME: _____ **DATE OF INJURY:** _____

COMPANY NAME: _____ **PHONE:** _____

COMPANY ADDRESS: _____ **FAX:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **PO/JOB #:** _____

SUPERVISORS NAME: _____ **PHONE:** _____

SEND REPORTS VIA: **FAX** _____ **E-MAIL** _____

MAIL _____ **OTHER** _____

****SERVICES RENDERED ON CHECKED ITEMS ONLY****

<p><u>WORK COMP INJURY</u></p> <p><input type="checkbox"/> Bill Above Named Company</p> <p><input type="checkbox"/> Bill Workers Comp Insurance Carrier: It is the responsibility of the company to call in a First Report of Injury (Form IA-1) to your workers' compensation insurance carrier. Please provide carrier info and claim number below.</p> <p style="text-align: center;">Workers Comp Insurance Carrier</p> <p>Company: _____</p> <p>Phone: _____</p> <p>Address: _____</p> <p>Adjustor: _____</p> <p>City: _____</p> <p>State: _____ Zip: _____</p> <p>Claim No.: _____</p> <p>Your assistance in providing the claim number for this injury will expedite the management of this injury and the processing of claims.</p>	<p><u>DRUG SCREEN</u></p> <p><input type="checkbox"/> DOT</p> <p><input type="checkbox"/> Non-DOT</p> <p><input type="checkbox"/> DOT Collection</p> <p><input type="checkbox"/> Non-DOT Collection</p> <p><input type="checkbox"/> Quick Screen</p> <p><input type="checkbox"/> Hair</p> <p><input type="checkbox"/> Other _____</p> <p><u>ALCOHOL TESTING</u></p> <p><input type="checkbox"/> DOT</p> <p><input type="checkbox"/> Non-DOT</p> <p><input type="checkbox"/> Breath</p> <p><input type="checkbox"/> Saliva</p> <p><input type="checkbox"/> Other _____</p> <p><u>REASON FOR TEST</u></p> <p><input type="checkbox"/> Post Accident</p> <p><input type="checkbox"/> Pre-employment</p> <p><input type="checkbox"/> Random</p> <p><input type="checkbox"/> Other _____</p> <p><u>PHYSICAL EXAMS</u></p> <p><input type="checkbox"/> Non-DOT</p> <p><input type="checkbox"/> DOT</p> <p><u>OTHER</u></p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p>
---	---

AUTHORIZED BY: _____ **TITLE:** _____
(PRINT NAME) (REQUIRED)