Hours: Everyday 8am-8pm – Open Holidays

AUTHORIZATION TO TREAT

COMPANY NAME: ____________________________________________________________

CONTACT PERSON: __________________________________________________________

PHONE: (   )_________________  FAX: (   )________________________

INSURANCE COMPANY: ______________________  PHONE: (   )_________________

PATIENT NAME: _____________________________________________________________

☐ INJURY BODY PART(S): ____________________________________________________

☐ TB SKIN TEST  ☐ QUESTIONARE/CERTIFICATE  ☐ CHEST X-RAY

☐ DOT EXAM  ☐ DOT DRUG SCREEN*  ☐ NON-DOT DRUG SCREEN*

☐ RAPID DRUG SCREEN  ☐ 5-PANEL  ☐ 10-PANEL  ☐ 12-PANEL

☐ PHYSICAL EXAM  ☐ C-3  ☐ LIC 503  ☐ PRE-EMPLOYMENT

☐ OTHER:  ________________________________________________________________

Treatment Authorized by:  ________________________________________________

Print  _____________________________  __________________________

Signature  Date

WWW.XURGENTCARE.COM

*This will be sent to a separate lab for testing.  REV. 10.15.19