



**Rocky Mountain**  
**Urgent Care &**  
**Family Medicine**

**EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT**

*(MUST PRESENT PHOTO ID AT TIME OF SERVICE)*

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Company Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address / Location #: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

**Authorization for Medical Treatment**

Person Authorizing: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Type of Injury: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**BILLING**

\_\_\_\_ Bill Workers' Compensation Carrier

Carrier: \_\_\_\_\_

Policy #: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Claim#: \_\_\_\_\_

\_\_\_\_ Billing company for services

Bill to: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_ Employee to pay at time of service

**PHYSICAL EXAMINATIONS**

Job Title: \_\_\_\_\_

\_\_\_\_ DOT

\_\_\_\_ DOT Replacement

\_\_\_\_ DOT Recertification

\_\_\_\_ Post Offer Exam (Pre-Employment)

\_\_\_\_ Other

Special Instructions: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DRUG TESTING**

**Drug Testing**

\_\_\_\_ Regulated (DOT)

\_\_\_\_ Non-Regulated (Non-DOT)

\_\_\_\_ Urine Collection Only

\_\_\_\_ Rapid Test

**TEST TYPE**

\_\_\_\_ Preplacement

\_\_\_\_ Random

\_\_\_\_ Reasonable Suspicion

\_\_\_\_ Post Accident

\_\_\_\_ Periodic

\_\_\_\_ Follow-up

\_\_\_\_ Return to Duty

\_\_\_\_ Return to Duty

Designated Employer Representative: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

**Does your Company have a written drug screen policy?** \_\_\_\_\_



## Drug Testing Consent Form

Date of Drug Screen: \_\_\_\_\_

I understand that I agree to undergo a drug test. I hereby authorize Rocky Mountain Urgent Care and Family Medicine to conduct such testing and to provide the results to a representative of (name of employer/Company) \_\_\_\_\_ . I release (name of employer/company) \_\_\_\_\_ and the person and organization conducting the testing from liability therefore.

Donor Name (print): \_\_\_\_\_

Donor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name (print): \_\_\_\_\_

Witness Signature: \_\_\_\_\_