

Authorization for Treatment

THIS FORM SERVES AS AN AUTHORIZATION TO PROVIDE TREATMENT AND/OR TESTING FOR THE FOLLOWING:

Date: ____/____/____ Employee: _____

Employer: _____

Authorized By: _____ Phone: ____-____-____

TYPE OF SERVICES TO BE PROVIDED: (CHECK ✓ REQUESTS)

- Injury or Illness Care > Include Post Accident : Drug Screen Breath Alcohol Test
- Physical Exam
 - Pre-Employment/Post Offer
 - Return to Work
 - Annual
 - Haz-Mat
 - DOT Medical Clearance
 - Other: _____
- Drug and/or Alcohol Screen Please Specify Type Below
 - DOT Drug Test
 - Non-DOT Drug Test
 - DOT Breath Alcohol Test
 - Non-DOT Breath Alcohol Test
 - Pre-Employment
 - Post Accident
 - Return to Duty
 - Random
 - Reasonable Suspicion
 - Follow Up
- Other Service(s): _____

******NOTE TO EMPLOYEE: PICTURE ID IS REQUIRED FOR ALL SERVICES******

Inspira Urgent Care Vineland

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