DoctorsNow walk-in care

Employer Authorization Form

Employer Information	**Patient Information**
Company Name:_____	Name:_____
Address:_____	SSN:_____
City, State, Zip:_____	DOB:_____
Phone:_____	Phone:_____

Workman's Compensation Section

Work Comp Injury? __Yes __No Date of Injury:_____

Type of Injury:_____

Insurance Company:_____ Policy #:_____

Address:_____ Contact:_____

City, State, Zip:_____ Phone:_____

Urine Drug Testing

DOT Regulated __FMCSA __FAA __FRA __FTA __PHMSA __USCG

__Pre-employment __Random __Reasonable Suspicion __Post Accident __Return to Duty __Follow-Up

__Use DoctorsNow MRO __Company Form on Hand __Collection Only __DOT eScreen

__**Breath Alcohol Test** – Altoona Only __**Saliva Test** – Available All Locations

NON-DOT __Pre-employment __Random __Reasonable Suspicion __ Post-Accident __Return to Duty __Follow-Up

___iCUP __eScreen __Company Form on Hand __Collection Only ___mCUP

PHYSICALS __DOT Physical __Standard Physical __Respiratory Physical __Return to Duty

OTHER TESTS __Audiogram – Altoona Only __PFT – Altoona/Johnston

__TB Test __Other:_____

Person Authorizing Services

Name:_____ **Title:**_____

Phone:_____ **Date:**_____

Please fax completed form to the appropriate clinic. DoctorsNow reserves the right to refuse non-life threatening treatment if form is not completed.

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