



## MEDICAL AUTHORIZATION

Date: \_\_\_\_\_

The completion of this form authorizes examination of \_\_\_\_\_

SS#: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

In accordance with pre-employment/clinical needs, this authorizes treatment exclusively by Boerne/Bulverde Urgent Care & Occupational Health.

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

**Clinical**

- Injury Care
- Illness
- Other: \_\_\_\_\_

**Drug Screen**

- 5 panel rapid
- 10 panel rapid
- MRO/DOT
- Escreen
- Medtox
- CRL
- Quest
- Kroll
- Lab Corp

**Reason for Test**

- Just cause/reasonable
- Pre-Employment
- Periodic
- Random
- Post Accident

**Physical Examination**

- Pre-Employment
- DOT
- Return to Duty

**Alcohol**

- Breathalyzer (BAT)
- Other: \_\_\_\_\_

As part of the employers hiring process and/or when a job related injury occurs, please send the above named employee directly to the Boerne/Bulverde Urgent Care & Occupational Health Center.

Company Name: \_\_\_\_\_ Div# Store #: \_\_\_\_\_

Authorized by: \_\_\_\_\_ Title: \_\_\_\_\_

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