



URGENT CARE

YOUR DEPENDABLE URGENT CARE

2265 South Linden Road.

Flint, MI 48532

Phone: 810-720-8700 Fax: 810-720-3393

AUTHORIZATION FOR EXAMINATION OR TREATMENT

Employee Name: _____ Job Title: _____

Employer: _____ Address: _____

Work Related:

___ Call me at (____) _____ after
employee is seen by the physician.

___ Injury
(Specify) _____

___ Substance Abuse Drug Screen
Type: ___DOT ___Non-DOT

Reason: ___ Post Offer/Pre-Hire
___ Post Injury (Non-DOT Work Comp)
___ Post Accident (DOT Work Comp)
___ Reasonable Cause
___ Random
___ Periodic
___ Follow Up
___ Evidential Breath Test (Breath/Alcohol)

Physical Exam:

- Post Offer/Pre-Hire
- DOT (Initial/Recent)
- Dept. of Education
- Return to Work
- Baseline Haz Mat
- Annual Haz Mat
- Exit Haz Mat

Other Tests:

- Audiogram
- Back Evaluation
- Chest X-Ray
- EKG
- Essential Job Function
- Hepatitis B Vaccine
- Hepatitis B Antibody Titre
- PPD (TB Test)
- Pulmonary Function Test (PFT)
- Respiratory Evaluation
- Tetanus
- Lab Collection

Special Instructions (Please Print)

Authorized By: Kari Conner
(Signature)

Kari Conner
(Print)

Phone: (989) 631-6691/ Fax (989) 631-8760 Date: _____

Title: Human Resources Manager

Billing Address and Contact: _____

Consent for Release of Information:

I hereby authorized Genesee Urgent Care, its physicians, nurses, clerical staff, technicians, and laboratories to release any information pertinent to this specific injury/illnesses and or physical examination and/or drug or alcohol screen results to my Employer, Prospective Employer, Employer's Medical Review Officer or Third Party Administrator.

In addition, I hereby release Genesee Urgent Care, it's physicians, nurses, clerical staff, technicians, and laboratories from any and all claims of actions resulting from the disclosure of these results.

Employee Signature: _____ Date: _____