MOUNT CARMEL
URGENT CARE

GROVE CITY
3000 Meadow Pond
Ste 200
Grove City, OH 43123
Phone: (614) 871-7130 Fax: (614) 377-3690

AUTHORIZATION FORM

Send the form with your employee or **fax** it to: **(614) 377-3690** **DATE:** _____

EMPLOYEE NAME: _____ **DATE OF INJURY:** _____

COMPANY NAME: _____ **PHONE:** _____

COMPANY ADDRESS: _____ **FAX:** _____

CITY: _____**STATE:** _____**ZIP:** _____**PO/JOB #:**_____

SUPERVISORS NAME: _____ **PHONE:** _____

SEND REPORTS VIA: □ **FAX** _____□ **E-MAIL**_____

□ **MAIL**_____□ **OTHER**_____

******SERVICES RENDERED ON CHECKED ITEMS ONLY******

WORK COMP INJURY

□ Bill Above Named Company

□ Bill **Workers Comp Insurance Carrier**: It is the responsibility of the company to call in a First Report of Injury (Form IA-1) to your workers' compensation insurance carrier. Please provide carrier info and claim number below.

Workers Comp Insurance Carrier
Company: _____
Phone: _____
Address: _____
Adjustor: _____
City: _____
State: _____Zip: _____
Claim No.: _____

Your assistance in providing the claim number for this injury will expedite the management of this injury and the processing of claims.

DRUG SCREEN

□ DOT
□ Non-DOT
□ DOT Collection
□ Non-DOT Collection
□ Quick Screen
□ Hair
□ Other _____

ALCOHOL TESTING

□ DOT
□ Non-DOT
□ Breath
□ Saliva
□ Other _____

REASON FOR TEST

□ Post Accident
□ Pre-employment
□ Random
□ Other _____

PHYSICAL EXAMS

□ Non-DOT
□ DOT

OTHER

□ _____
□ _____

AUTHORIZED BY:_____ **TITLE:**_____
(PRINT NAME) (REQUIRED)