MOUNT CARMEL
URGENT CARE

HAMILTON
4965 North Hamilton Road
Columbus, Ohio 43230
Phone: (380) 201-1330 Fax: (614) 532-1573

AUTHORIZATION FORM

Send the form with your employee or **fax** it to: **(614) 532-1573** **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)