



12660 Riverside Drive, Suite 110, Valley Village, CA 91607
Phone 818.761.1800 • Fax 818.761.1811
www.studiocityurgentcare.com

TREATMENT AUTHORIZATION FORM

EMPLOYER INFORMATION:

Name: _____
Company Name: _____
Position: _____
Company Phone: _____
Company Fax: _____
Contact Person/Supervisor: _____

Please provide medical treatment necessary for the proper care of the above named employee.

Date of Inquiry / Illness: _____
Type of Inquiry / Illness: _____

Please perform the following exams:

- Pre-employment DOT with lumbar
- DOT Others _____
- Respiratory _____
- Drug / Alcohol Screening:
 - 5 Panel 10 Panel Collection Only

Other Services:

- Pulmonary Function Test BAT
- Audiogram TB Skin Test
- Hepatitis B ECG
- Xray Flu Shot

Bill services to:

- Work Compensation Insurance Carrier: _____
- Employer
- Employee pays at the time of service

Treatment is authorized by: _____
on behalf of (company) _____