Authorization to Evaluate or Treat at QUCW

Quality Urgent Care and Wellness (QUCW) are authorized by ____________________(employer) and the following Supervisor __________________________to perform the following for the Employee listed below starting on Date: ______________.

Employee Information:

Name (First, Last): ______________________

Date of Birth: ______________________

SSN and Employee ID or Claim Number: ______________________

Employer: ______________________ Phone: ______________________

Address: ______________________

Point of Contact: (Person QUCW can contact for issues or concerns)

Name (First, Last): ______________________

Phone: ______________________ Fax: ______________________

Address: ______________________

Email: ______________________

Choose Service QUCW to complete today:

OCCUPATIONAL HEALTH

☐ Rapid Urine Drug Screen

☐ Chain of Custody (Employee brings form)

☐ Breath Alcohol Screening

☐ DOT Physical

☐ OSHA Fit Testing

Bill to the Following:

Employer Name: ______________________

Address: ______________________

Email: ______________________ Fax: ______________________

WORKERS COMP

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In addition to a Workplace injury evaluation, QUCW shall perform the following services:

☐ Breath Alcohol Testing

☐ Tetanus Shot

☐ Rapid Urine Drug Screening

☐ Other: ______________________

Bill to the Following Workers Comp Company:

Company Name: ______________________

Address: ______________________

Email: ______________________ Fax: ______________________

Policy Number to Avoid Billing to Employer: ______________________