

TREATMENT AUTHORIZATION



801 Corporate Center Drive
Suite 130
Pomona, CA 91768
Phone (909) 623-1954
Fax (909) 623-4988

Hours
Monday - Friday
7:30 a.m. - 6:00 p.m.

DATE: _____

TIME: _____ AM PM

PATIENT NAME: _____

Services Requested

- Injury Date of Injury: _____ Last Worked: _____
- Injured Body Part: _____
Occurred At: _____ County: _____
- Return to Work Evaluation
- Express Test
- Physical Exam Type: _____
- Drug / Alcohol Test. Please specify below:

- | | |
|---|---|
| <input type="radio"/> DOT DRUG TEST | <input type="radio"/> Pre-Placement <input type="radio"/> Random |
| <input type="radio"/> NON-DOT DRUG TEST | <input type="radio"/> Post-Accident <input type="radio"/> Post-Injury |
| <input type="radio"/> DOT BREATH ALCOHOL TEST | <input type="radio"/> Return to Duty <input type="radio"/> Follow Up |
| <input type="radio"/> NON-DOT BREATH ALCOHOL TEST | <input type="radio"/> Reasonable Suspicion |

PICTURE ID REQUIRED!

Does Employee Work for a Temp / Leasing Company? No _____ Yes _____

Employer: _____ Dept: _____

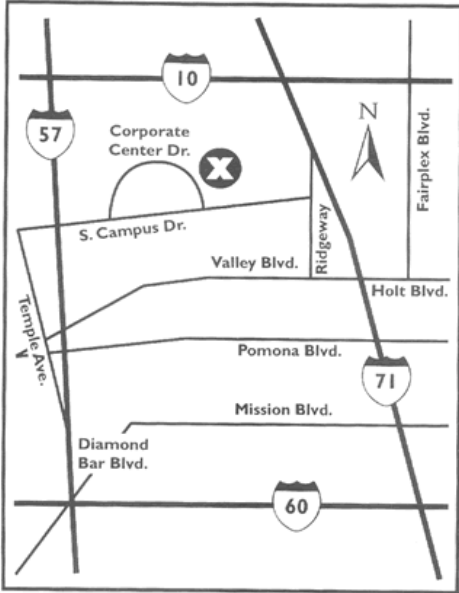
Telephone: _____ WC Insurance: _____

Authorized By: Print: _____

Title: _____

Signature: _____ () Verbal

LOCATION



POMONA

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