



**SOUTH GEORGIA
IMMEDIATE
CARE CENTER**
STATESBORO
1096 Bermuda Run Rd
Statesboro, GA 30458
Phone: (912) 871-5150 Fax: (912) 871-5154

AUTHORIZATION FORM

Send the form with your employee or **fax** it to: (_____) _____ **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****

<p><u>WORK COMP INJURY</u></p> <p><input type="checkbox"/> Bill Above Named Company</p> <p><input type="checkbox"/> 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.</p> <p style="padding-left: 40px;">Workers Comp Insurance Carrier Company: _____ Phone: _____ Address: _____ Adjustor: _____ City: _____ State: _____ Zip: _____ Claim No.: _____</p> <p>Your assistance in providing the claim number for this injury will expedite the management of this injury and the processing of claims.</p>	<p><u>DRUG SCREEN</u></p> <p><input type="checkbox"/> DOT <input type="checkbox"/> Non-DOT <input type="checkbox"/> DOT Collection <input type="checkbox"/> Non-DOT Collection <input type="checkbox"/> Quick Screen <input type="checkbox"/> Hair <input type="checkbox"/> Other _____</p> <p><u>ALCOHOL TESTING</u></p> <p><input type="checkbox"/> DOT <input type="checkbox"/> Non-DOT <input type="checkbox"/> Breath <input type="checkbox"/> Saliva <input type="checkbox"/> Other _____</p> <p><u>REASON FOR TEST</u></p> <p><input type="checkbox"/> Post Accident <input type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> Other _____</p> <p><u>PHYSICAL EXAMS</u></p> <p><input type="checkbox"/> Non-DOT <input type="checkbox"/> DOT</p> <p><u>OTHER</u></p> <p><input type="checkbox"/> _____ <input type="checkbox"/> _____</p>
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AUTHORIZED BY: _____ **TITLE:** _____
(PRINT NAME) (REQUIRED)