FAIC
FALLS AVENUE IMMEDIATE CARE

EMPLOYER'S AUTHORIZATION FOR EXAMINATION AND TREATMENT

Must Present Photo ID at Time of Service • Clinic Location and Contact Information on Back

Company Name _____ Patient Name _____
Authorized: **Signature** _____ Patient Address _____
Authorized: **Print** _____ Patient Phone _____
Employer Phone _____ Patient DOB _____ SS# _____
Employer Fax _____Staffing Agency _____

☐ Bill Company ☐ Employee pays at time of service ☐ Bill Workers' Compensation Carrier
Carrier _____ Policy # _____ Phone # _____
Address _____

INJURY

INJURY TREATMENT/EVALUATION

☐ Treatment of work-related injury or illness — Date of Injury
What is the type/area of injury or illness: — Time of Injury
☐ Drug Screen with initial visit

PHYSICAL EXAMS

NON-DOT PROCEDURES	DOT PROCEDURES
PHYSICAL EXAMINATION	**PHYSICAL EXAMINATION**
☐ Post Offer/ Pre-employment ☐ Asbestos ☐ Basic ☐ Annual ☐ Exit ☐ Return to work ☐ Hazmat ☐ Basic ☐ Annual ☐ Exit ☐ Fit for Duty ☐ Respirator ☐ New ☐ Recertification ☐ Other	☐ New ☐ Recertification ☐ Follow-up

DRUG TEST

DRUG TEST – TYPE	DRUG TEST – FEDERALLY MANDATED
☐ Rapid/Instant (Select Panel Type) 5 10 Reason for Drug Test ☐ Pre-employment ☐ Return to Work ☐ Random ☐ Follow-up Testing ☐ Reasonable Suspicion/ Cause ☐ Other ☐ Post Accident	☐ Urine Reason for Drug Test ☐ Pre-employment ☐ Return to Work ☐ Random ☐ Follow-up Testing ☐ Reasonable Suspicion/ Cause ☐ Other ☐ Post Accident

OTHER

☐ Hepatitis B Surface Antibody ☐ Chest X-Ray/Back X-Ray ☐ EKG ☐ Labs	☐ Back Evaluation ☐ TB Single ___ 2 Step ___ ☐ Audio Test ☐ Vision Test (Titmus) ☐ Lift Test _____lbs. ☐ Knee Level ☐ Waist Level

COMPANY INSTRUCTIONS

Other Testing and/or Company Specific Instructions:

FALLS AVENUE IMMEDIATE CARE INSTRUCTIONS: Please arrive no later than 30 minutes prior to close.
PHYSICAL EXAM: Please bring your glasses or contacts. Do **NOT** urinate prior to arrival.
DRUG SCREENING: Do **NOT** urinate prior to arrival.

RELEASE OF INFORMATION: The signed authorization guarantees payment for services requested on this and medical services necessary for proper treatment of injuries and illnesses. This release is also intended to certify that I (the Patient) give Business Health Solutions, or an affiliated clinic, authorization to release all information regarding this examination, testing results or treatment to my employer, prospective employer or employer's insurer.

Employee/Patient Signature: _____ **Date:** _____/_____/_____