PromptMed™ URGENT CARE
Neighborhood Walk-In Medical Clinics

EMPLOYER AUTHORIZATION FORM

Please have your employee present this form upon check-in, or fax it ahead of time to the appropriate clinic number below.

COMPANY NAME: _____ **DATE OF REQUEST:** _____

EMPLOYEE NAME: _____ **THIS REQUEST EXPIRES AFTER:** _____

SOCIAL SECURITY # (required for work injury): _____ **EMPLOYEE PHONE #:** _____

If a drug screen is needed, the employee must have a valid photo ID. If not able to provide an ID, the Direct Employer Representative (DER) will need to be present.

WORK INJURY/ILLNESS

☐ Initial Injury Treatment
- Date of Injury: _____
- Description/Body Part: _____

☐ Injury Follow Up

DRUG & BREATH ALCOHOL TESTING (complete both sections)

1. Reason for Testing:
- ☐ Annual/Re-Certification
- ☐ Pre-Employment
- ☐ Post-Accident
- ☐ Random
- ☐ Return to Duty
- ☐ Reasonable Suspicion
- ☐ Other: _____

2. Type of Testing:
- ☐ Non-Federal
  - ☐ Urine Drug Test
    - ☐ 4-Panel (Excl. THC)
    - ☐ 5-Panel
    - ☐ 9-Panel (Excl. THC)
    - ☐ 10-Panel
  - ☐ Hair (7-Panel)
  - ☐ Breath Alcohol Test
- ☐ Federal/Department of Transportation (DOT)
  - ☐ Urine Drug Test
  - ☐ Breath Alcohol Test

PHYSICALS

☐ DOT Physical
- ☐ Pre-Placement
- ☐ Re-Certification

☐ Non-DOT Physical
- ☐ Illinois School Bus Driver Physical
- ☐ Wisconsin School Bus Driver Physical
- ☐ Pre-Employment
- ☐ Return to Work
- ☐ Respirator Physical (incl. PFT/Spirometry & OSHA)
- ☐ Asbestos Physical (incl. Chest X-Ray, PFT/Spirometry & OSHA)

☐ Other: _____

OTHER SERVICES

☐ Lift Test (_____lbs.)
☐ Respirator Mask Fit Test
☐ PFT/Spirometry
☐ Audiometry
☐ TB/PPD (Tuberculosis)
** Employee must return in 48-72 hours to have test read.*
☐ Other: _____

VACCINES

☐ Tetanus (Td / Tdap) Vaccination
☐ Flu Vaccination
☐ Hepatitis B Vaccination (3-Part Series) ___1____2_____3
☐ Other: _____

Please <u>check one</u> of the boxes below:

☐ Bill the company's worker's compensation insurance carrier
☐ Bill the company directly
☐ Credit card or company check has been provided by the company to pay for services rendered
☐ Patient's responsibility to pay for services rendered

Please evaluate and treat above mentioned employee for current visit and any required follow up services needed. No services will be performed unless it is marked or unless your profile specifically states to do so.

Authorized by: _____ Title: _____

Date: _____ Phone: _____

Antioch 420 E. IL Route 173, Suite 101, Antioch, IL 60002 | Phone: 847.652.9700 | Fax: 847.652.9710
Gurnee/Waukegan 724 N. Green Bay Road, Waukegan, IL 60085 | Phone: 847.901.8400 | Fax: 847.901.8410
Highland Park 1849 Green Bay Rd., # 171, Highland Park, IL 60035 | Phone: 224.243.7600 | Fax: 224.243.7610
Hours of Operation Monday-Friday: 8:00AM – 8:00PM | Saturday & Sunday: 9:00AM – 5:00PM

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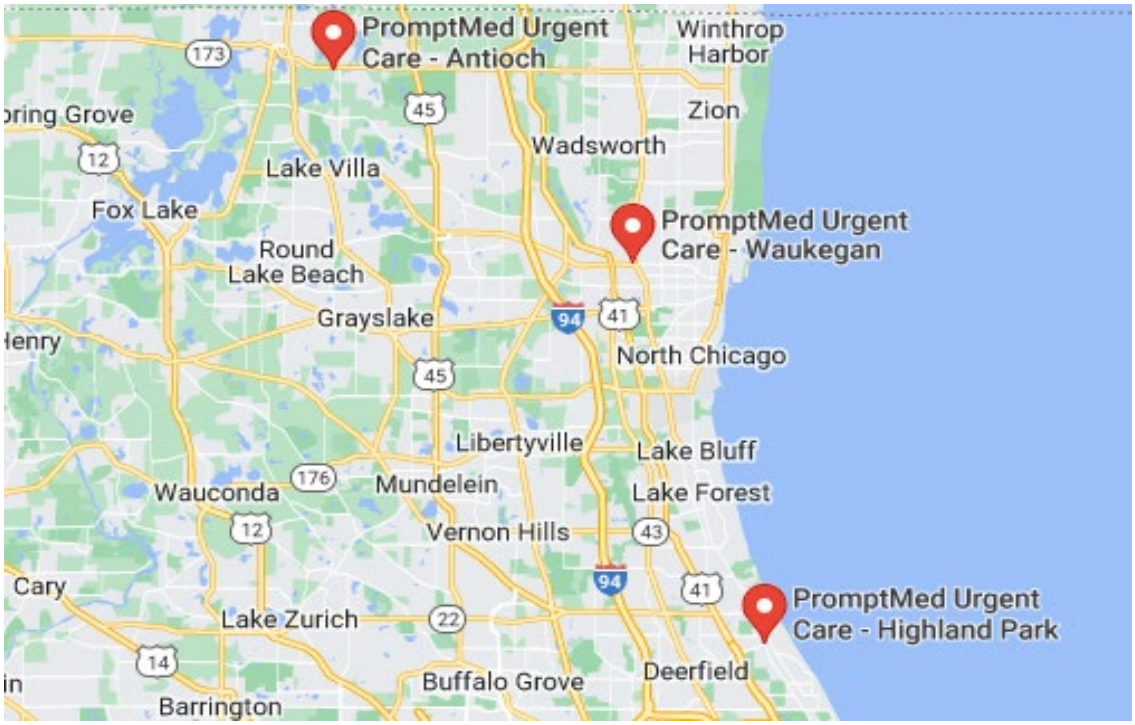

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