Holy Cross Urgent Care
A Member of Trinity Health

RIO VISTA
1115 S Federal Hwy
Fort Lauderdale, FL 33316
Phone: (954) 764-6646 Fax: (954) 533-4322

AUTHORIZATION FORM

Send the form with your employee or **fax** it to: **(954) 533-4322** **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******

WORK COMP INJURY

☐ Bill Above Named Company

☐ 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.

Workers Comp Insurance Carrier
Company: _____
Phone: _____
Address: _____
Adjustor: _____
City: _____
State: _____Zip: _____
Claim No.: _____

Your assistance in providing the claim number for this injury will expedite the management of this injury and the processing of claims.

DRUG SCREEN

☐ DOT
☐ Non-DOT
☐ DOT Collection
☐ Non-DOT Collection
☐ Quick Screen
☐ Hair
☐ Other _____

ALCOHOL TESTING

☐ DOT
☐ Non-DOT
☐ Breath
☐ Saliva
☐ Other _____

REASON FOR TEST

☐ Post Accident
☐ Pre-employment
☐ Random
☐ Other _____

PHYSICAL EXAMS

☐ Non-DOT
☐ DOT

OTHER

☐ _____
☐ _____

AUTHORIZED BY:_____ **TITLE:**_____
(PRINT NAME) (REQUIRED)