

Concentra

EMPLOYER'S AUTHORIZATION FOR WALK-IN EXAMINATION OR TREATMENT (MUST PRESENT PHOTO ID AT TIME OF SERVICE)

PATIENT NAME: _____

COMPANY NAME: CITY OF SPRINGFIELD

DEPARTMENT _____

SCHOOL _____

DATE OF BIRTH: _____

DATE OF INJURY: _____

WORK-RELATED _____ **INJURY** _____ **ILLNESS** _____

Post Accident Substance Abuse Testing:

____ Drug Screen

____ Breath Alcohol

____ Urine Collection Only

TEST TYPE

____ DOT Regulated

____ Non-Regulated

COMMENTS:

SUPERVISOR:

IN ORDER TO SEE YOUR INJURED
EMPLOYEE IN A TIMELY MANNER PLEASE
SEND THIS FORM WITH THE
EMPLOYEE OR YOU MAY FAX IT
AHEAD OF TIME TO 413-746-3230.
IF AN EMPLOYEE DOES NOT PRESENT
WITH THIS FORM TIME WILL BE SPENT
TRYING TO VERIFY EMPLOYMENT.

******* NO PHONE CALL TO CONENTRA IS
NECESSARY IF THIS FORM
IS SENT IN.**

Authorized By: _____
(signature)

Printed Name: _____

Title: _____

Date: _____

Phone: _____