General Authorization Form

1. Employer Information

Company Name: _____

Contact Person (Name & Title): _____

Phone Number: _____

Email Address: _____

2. Employee Information

Employee Full Name: _____

Date of Birth: _____

3. Occupational Medicine Services (Check all that apply)

☐ Pre-Employment Physical

☐ DOT Physical

☐ Non-DOT Physical

☐ DOT/Federal Drug Screen

☐ Drug Screen (specify: 5-panel, 10-panel, instant, send out, etc.) _____

☐ Saliva Alcohol Test (DOT or NON-DOT)

☐ Respirator Fit Test

☐ TB Skin Test or TB Gold/ Chest X-Ray

☐ Titers (specify: Hep B or MMR) _____

☐ Vaccines (Influenza or Tetanus) _____

☐ Injury Evaluation

☐ Return-to-Work Clearance

☐ Other: _____

4. Worker's Compensation

Worker's Comp Injury? ☐ Yes ☐ No

Need Drug Screen? ☐ Yes ☐ No

Date of Injury: _____

5. Authorization Statement

I authorize Urgent Care of Mountain View to perform the services indicated above for the employee named on this form. I confirm that this employee has been referred by our company for occupational medicine services, and I authorize the release of relevant results (e.g., drug screen findings, clearance status) to our organization, in compliance with HIPAA and applicable laws.

6. Signature Section

Employer Representative Signature: _____ Date: _____