TREATMENT AUTHORIZATION

Employer Must Complete AND Send With Employee/Donor

OR

Fax to: (209) 832-2210 or (209) 832-1701

Date: _____

MEDICAL TREATMENTS REQUESTED

- ☐ **DMV PHYSICAL**
- ☐ **PRE-EMPLOYMENT PHYSICAL**
- ☐ **BAT (BREATH ALCOHOL TEST)** ***BY APPOINTMENT ONLY***
- ☐ **FORENSIC NON-DOT DRUG SCREEN ONLY**
- ☐ **FEDERAL DOT DRUG SCREEN ONLY**
- ☐ **RAPID DRUG SCREEN**

Please choose and fill out billing information below

- _____ **Bill MRO (Medical Review Officer)**
- _____ **Bill Employer**
- _____ **Bill Employee (To be paid at time of service)**

Employee Name: _____

SSI#: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Cell #: _____

Visit Authorized By: _____

Phone #: _____ Fax #: _____

BILL TO: (First-Aid) or (Pre-Employment)

Employer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

BILL TO: (Name on Chain of Custody Drug Screen)

MRO: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

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