EMPLOYER REQUEST FOR EXAMINATION/TREATMENT

Please have your employee(s) provide this form at the time of visit. You are also welcome to fax this prior to your employee(s) visit.
Form must include a designated employee representative and phone number. No appointment is necessary.

Date of Request:____________________ *Requests are kept for a period of one month from the 'Date of Request' field.

Employee Name:______________________________ Date of Birth: ____________________

Company Name:____

Company Phone:____________________ Company Fax:____________________

Company Address:____
Street Address City/State/Zip Code

Designated Employee Rep (DER):____________________ DER Phone:____________________

REASON FOR REQUEST EXAM/TREATMENT

Pre-employment Post-Accident Return-to-Duty Random Reasonable Cause
Workers Compensation/Work Related Injury Other:____________________
***Please complete section 'For Work Related Injury Only below

FOR WORK RELATED INJURY ONLY

Work Restrictions Availability: Modified Light No Duty Available
Additional Procedure(s): Yes No (If yes, please check all that apply in the 'Requested Service(s) below)

WC INSURANCE:____________________ CLAIM NUMBER if applicable____________________

ADJUSTER NAME:____

PHONE NUMBER:____________________ FAX NUMBER:____________________

***We will notify you if your employees' injury requires First Aid Treatment vs. Workers Compensation (OSHA Recordable).
First Aid Treatment is billed directly to the company using our Fee for Service rates and not to the insurance carrier***

HOW WOULD YOU LIKE TO RECEIVE RESULTS &/OR MEDICAL TRANSCRIPT? DOT Panel

[ADVENTISTHEALTH:INTERNAL]

EMPLOYER AUTHORIZATION

Authorized by:____ ____

Signature Print Name

By signing I am authorizing services and hereby making a guarantee of payment for services requested on

Revise date: 11/30/2021