ATTN: Worker's Compensation Authorization Department
Phone: (803) 757-4921
Fax: (803) 774-5016

Date: _____ Date of Birth: _____

Patient Name: _____ Date of Injury: _____

Company Name: _____

Company Address: _____

Contact Person: _____ Phone: _____ Fax: _____

Nature of Injury:

_____

_____

_____

_____

Substance Abuse Testing Required:

Breath Alcohol: ( ) Yes ( ) No

Drug Screen: ( ) Yes ( ) No

If yes, rapid drug screen ( ) or MRO ( )

Workers' Compensation Carrier: _____

Workers' Compensation Claim #: _____

Treatment Authorized By: _____ _____
Print Name Title

_____
Signature