FAST CARE

NO APPOINTMENT NECESSARY

AUTHORIZATION FORM for TREATMENT

Employee Name: _____ **Date:** _____

Employer Name: _____
Phone #:_____ **Fax #:**_____
Employer Address: _____

Contact Person: _____
E-mail address_____

Specify body part to be treated: _____
Date of injury: _____

Insurance Carrier: _____ **Phone:** _____

WORK COMP INJURY INFORMATION

Work Related Injury	[ ] Yes	[ ] No	
Light Duty Available	[ ] Yes	[ ] No	
Drug Screen required with injury	[ ] Yes	[ ] No	(if yes, please check type below)
Urine Drug Screen	[ ] Non-DOT	[ ] DOT	[ ] Collection only
Alcohol Test	[ ] Yes	[ ] No	
	[ ] Blood	[ ] Breath	

PHYSICAL INFORMATION

Pre-Placement Physical	[ ] Yes	[ ] No	**DOT Physical**	[ ] Yes	[ ] No
PPD	[ ] Yes	[ ] No	**EKG**	[ ] Yes	[ ] No
CBC	[ ] Yes	[ ] No	**Urine Drug screen**	[ ] Yes	[ ] No
CMP/Smac	[ ] Yes	[ ] No		[ ] Non-DOT	[ ] DOT [ ] Collection only
Chest X-ray	[ ] Yes	[ ] No	**Alcohol Test**	[ ] Yes	[ ] No
				[ ] Blood	[ ] Breath

Hepatitis B Injection 1st _____ 2nd _____ 3rd _____

Comments:
_____
_____

Authorized By: _____ **Date:** _____

Location: 825 Arthur Godfrey Rd. Suite #100, Miami Beach, Fl. 33140
Hours: Mon – Fri 9:00am to 9:00pm
Saturday, Sunday 9:00am to 7:00pm
Holidays: 9:00 am to 5:00pm

Phone: 786-923-4000 | Fax: 786-923-4001 | Email: fastcare@myfastcare.com