



FAST CARE

**NO APPOINTMENT NECESSARY | OPEN 365 DAYS A YEAR
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
CBC Yes No
CMP/Smac Yes No
Chest X-ray Yes No
EKG Yes No
Urine Dip Yes No

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

Comments:

Authorized By: _____ **Date:** _____

AVENTURA CENTER	MIAMI BEACH CENTER
Address: 20601 E. Dixie Hwy, Suite #340 Aventura, FL 33180	Address: 825 Arthur Godfrey Rd, Suite #100 Miami Beach, FL 33140
Hours: Mon – Fri 9:00am to 9:00pm Sat – Sun 9:00am to 5:00pm Holidays 9:00am to 5:00pm	Hours: Mon – Fri 9:00am to 9:00pm Sat – Sun 9:00am to 7:00pm Holidays 9:00am to 5:00pm
Fax: 786-923-4001	Fax: 786-472-3035

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