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Toledo OH 43612
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NORTHWEST OHIO
URGENT CARE, INC.
NETWORK



[] 1015 Conant St
Maumee OH 43537
Ph: 419-891-0525
Fax: 419-891-1088

EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT

PATIENT NAME: _____ DATE: _____

Company Name & Physical Address:

PH: _____ FAX: _____
>BILLING ADDRESS FOR URINE COLLECTION IF 3RD PARTY:

PH: _____ FAX: _____

Billing Address(s) for Services Performed:

>BILLING ADDRESS FOR OTHER SERVICES (PLEASE SPECIFY)

PH: _____ FAX: _____
>BILLING ADDRESS FOR OTHER SERVICES (PLEASE SPECIFY)

PH: _____ FAX: _____

EMPLOYEE IS A: [] COMPANY EMPLOYEE [] CONTRACTED EMPLOYEE (PLEASE SPECIFY) _____

IS A POST ACCIDENT SUBSTANCE ABUSE TEST REQUIRED? YES NO

BREATH ALCOHOL TEST REQUIRED? YES NO

RESPONSIBLE PARTY: COMPANY DRIVER/SELF PAY OTHER: _____

PHYSICALS/EXAMS

- DOT
 GENERAL
 OTHER

OTHER SERVICES

- RESPIRATOR FIT EXAM
 PULMONARY FUNCTION TEST
 HEPATITIS B VACCINE
 OSHA STAND. LEAD LEVEL
 TB/PPD
 A1C=DIABETIC MONITORING
 OTHER: _____

DRUG SCREENS (Our MRO Only)

- DOT/NIDA : MRO - DR. HUSAIN (Our MRO)
 NON NIDA / 9 PANEL : MRO - DR. HUSAIN (Our MRO)
 NIDA LOOK ALIKE / 5 PANEL : MRO - DR. HUSAIN (Our MRO)
 INSTANT DRUG SCREEN : [] 9 PANEL [] 5 PANEL (BWC)
 HAIR SPECIMEN: MRO - DR. HUSAIN (Our MRO)

COLLECTIONS

- NIDA COLLECTION (Your MRO) _____
 NON NIDA COLLECTION (Your MRO) _____
 HAIR COLLECTION (Your MRO) _____

OTHER TESTING

- BREATH ALCOHOL: [] DOT [] NON-DOT

IS THE COMPANY WILLING TO PAY FOR HEMOGLOBIN A1C FOR EMPLOYEES WITH HIGH SUGAR? [] YES [] NO

REASON FOR TESTING: PRE-EMPLOYMENT RANDOM REASONABLE SUSPICION POST ACCIDENT
 RETURN TO WORK (OBSERVED) FOLLOW UP(OBSERVED)

ALL VERIFICATION SLIPS MUST BE FILLED OUT CORRECTLY AND COMPLETED BY THE DER FOR THE SERVICES TO BE RENDERED.
IF A DRUG SCREEN IS CHECKED OR REQUESTED AND WE HAVE NO PAPERWORK, WE WILL DO THE SCREEN ON OUR COC AND CHARGE ACCORDINGLY. AS PER THE AGREEMENT WITH NORTHWEST OHIO URGENT CARE, LLC, WE [THE COMPANY I REPRESENT] AGREE TO PAY FOR THE MEDICAL TREATMENT PROVIDED FOR THE INDIVIDUAL NAMED ABOVE.

DESIGNATED EMPLOYER REP:(PLEASE PRINT) _____

DER PHONE #: _____ DER FAX# _____