

Treatment Authorization

Autorización de Tratamiento



Please present this form at front desk. Presente este formulario en la recepción.

For physical exams arrive at least 1 hour before closing. Para los exámenes físicos, llegue al menos 1 hora antes del cierre

Name _____
Nombre

Injury Date _____
Fecha de la lesión

Employee Phone _____ **REQUIRED**
Teléfono del empleado

Email _____
Email

Employer _____
Empleador

Employer Phone _____
Teléfono del empleador

Insurance _____
Seguro de Compensación Laboral

Policy# _____
Número de Póliza

Is Modified Work Available? Yes Si No No
¿Está disponible el trabajo modificado?

Temporary Employee? Yes Si No No
¿Empleado temporal?

OCCUPATIONAL TREATMENT REQUESTED TRATAMIENTO OCUPACIONAL SOLICITADO

- Work Related Injury Treatment Post Accident/Injury Drug Screen Return to Work Evaluation (Fitness for Duty)

EMPLOYMENT RELATED EXAMINATION/TEST/IMMUNIZATIONS REQUESTED EMPLEO EXAMEN / PRUEBA / VACUNAS RELACIONADAS SOLICITADAS

- | | | |
|--|--|--|
| <input type="checkbox"/> DOT/DMV Physical | <input type="checkbox"/> Employment Physical | <input type="checkbox"/> RTW Physical |
| <input type="checkbox"/> DOT Drug Screen | <input type="checkbox"/> Drug Screen | <input type="checkbox"/> Drug Screen Collection Only |
| <input type="checkbox"/> Breath Alcohol Test | <input type="checkbox"/> Hepatitis B Injection | <input type="checkbox"/> Respirator Physical (OSHA) |
| <input type="checkbox"/> Respirator Fit Test | <input type="checkbox"/> Chest X-Ray | <input type="checkbox"/> Pulmonary Function Test |
| <input type="checkbox"/> Audio Test | <input type="checkbox"/> Other _____ | |

Signature _____
Firma

Date _____
Fecha

Santa Maria Clinic

3070 Skyway Drive
Suite 106
Santa Maria, CA 93455

805. 922. 8282 **P**
805. 925. 2690 **F**

Regular Hours

Mon-Fri: 7:30am-5:00pm
Saturday: Closed
Sunday: Closed
After Hours: Doctor on call: 805. 922. 8282