Employer Authorization for Examination or Treatment

Please email or fax this and all completed forms to the clinic listed above.

Patient's Name ____________________ Date ____________________

EMPLOYER REPRESENTATIVE

Please complete all information in this section before sending employee for treatment or services.

Employer Name ____________________ Employer Contact Name ____________________

Employer Address ____________________ Employer Contact Phone ____________________

City, State, Zip ____________________ Employer Contact Fax ____________________

Bill to Company/Employer

Workers' Comp Carrier

WORKERS' COMP CARRIER

WC Carrier Name ____________________ Phone __________ Fax __________

Address ____________________ City/State/Zip ____________________

AUTHORIZED SERVICES

AFC is authorized to provide the following services:

PHYSICALS	REASON FOR DRUG SCREEN	DRUG AND ALCOHOL	
		DOT	NON-DOT

OTHER SERVICES	LAB SERVICES	

____________________ ____________________

Signature of Employer Date

This AFC location is locally owned and operated by:

Updated: 01/2018