



# Peterson Occupational Health Services

2300 W. Peterson Ave. / CHICAGO, IL. 60659 / Tel. 773.508.9300 Alt (773) 910-9514 FAX 773.761.2112

## Authorization for Medical Treatment

Date / Time: \_\_\_\_\_

Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

### **Injury Care Treatment**

New Injury

Date / Time of Occurance \_\_\_\_\_

### **Physicals**

Post-Offer     Return to Work     DOT Post-Office Recertification

Other \_\_\_\_\_     DOT Recertification

### **Drug Abuse Testings**

Drug Screen     Express Drug Screen

DOT Drug screen     DOT Breath Alcohol

Breath Alcohol     Other \_\_\_\_\_

Lift Screen \_\_\_\_\_

### **Reason for Drug Abuse Testings**

Pre-Placement     Post Accident

Reasonable Cause/Suspicion     Random

Other \_\_\_\_\_

### **Other Miscellaneous Services**

Hepatitis B Vaccine     TB/PPD Test

Pulmonary Function Test     TB/PPD Reading

Audiogram

Other \_\_\_\_\_

**Work Related**     **Non-Work Related**

Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Workers Comp Number: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

FAX: \_\_\_\_\_

Email: \_\_\_\_\_

**Remarks:** \_\_\_\_\_

**NOTE: If the injury/illness should be found non-compensable we accept full responsibility for payments of all charges.**

**PRINT & SIGN NAME:** \_\_\_\_\_