OCCUPATIONAL MEDICINE CENTERS OF AMERICA

TREATMENT AUTHORIZATION FORM

DATE: _____ TIME: _____

SERVICES REQUESTED: ***(Please Check all Appropriate Boxes)***

_____WORKMANõS COMP INJURY (EVALUATION AND TREATMENT)*

DATE OF INJURY_____/_____/_____

INSURANCE COMPANY_____CLAIM#_____

BODY PART (S)_____

_____ DRUG TESTING _____BREATH ALCOHOL TESTING _____ PRE-EMPLOYMENT

_____ RANDOM _____ POST-ACCIDENT _____ REASONABLE SUSPICION _____OBSERVED

_____5 PANEL _____8 PANEL _____10 PANEL DOT_____ NON DOT _____

_____ PHYSICAL _____ IMMUNIZATIONS

_____PPD _____CHEST X-RAY _____HEP B SERIES _____TETANUS

COMPANY NAME_____

COMPANY ADDRESS_____

_____

EMPLOYEE/APPLICANTõS NAME_____

AUTHORIZED SIGNATURE_____

SUPERVISORõS NAME _____ PHONE # _____

OCCUPATIONAL MEDICINE CENTERS OF AMERICA

ADDRESS:

MAIN OFFICE
FLAMINGO PARK OF COMMERCE
12014 MIRAMAR PARKWAY
MIRAMAR, FL 33025
TELEPHONE: (954) 438-6228
FAX: (954) 437-1079
Email: omcausa@bellsouth.net

DANIA BEACH OFFICE
140 SOUTH FEDERAL HIGHWAY
DANIA BEACH, FL 33004
TELEPHONE: (954) 265-3406
FAX: (954) 437-1079
Email: occumedhlwd@bellsouth.net

- **PRIOR TO THE INJURED WORKER'S APPOINTMENT, PLEASE CONTACT THE WORKER'S COMP INSURANCE CARRIER AND HAVE THEM FAX THE FIRST REPORT OF INJURY AND A LETTER OF AUTHORIZATION FOR EVALUATION AND TREATMENT TO THE APPROPRIATE CENTER.**

OCCUPATIONAL MEDICINE CENTERS OF AMERICA

NAME OF WORKER'S COMP INSURANCE _____

BILLING ADDRESS _____

_____

_____

PHONE NUMBER _____ **FAX** _____

ADJUSTER'S NAME _____

ADJUSTER'S EMAIL _____

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