AFC Urgent Care - Anaheim
1711 W Katella Ave, Anaheim, CA 92804
Tel: (714) 400-2959 | Fax: (949) 216-3232
EMAIL TO: fot.anaheim@sunmedicalgrp.com

Employer Authorization for Examination or Treatment

Please email or fax this and all completed forms to the clinic listed above or send with employee

Patient's Name:

Patient's Job Title: Date:

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

Employer Name: Employer Contact:

Employer Address: Employer Contact Phone:

City: State: Zip: Employer Contact Fax:

WORKERS' COMP ☐ Protocol for Injury ☐ Protocol for Illness Bill to: ☐ Company/Employer: ☐ WC Carrier

WC Carrier Name: Phone: Fax:

Address: City/State/Zip:

Date/Time of Injury/Illness: W/C Claim #:

AUTHORIZED SERVICES *(Please select visit type and applicable services below.)* ☐ Workers' Comp ☐ Occupational Medicine

PHYSICALS	DRUG SCREEN	DRUG AND ALCOHOL		OTHER SERVICES
		DOT	NON-DOT	
		Please Select Chain of Custody:		
		☐ Employer CCF ☐ Clinic CCF ☐ ePassport ☐ Other: Specify_____		
____Return to Work	____Random	____Breath Alcohol	____Breath Alcohol	____Spirometry
____Pre-Employment Physi	____Pre-Employment	____Urine Drug Screer	____In-House Rapid (5 Pa	____Audiometry (Hearing Test)
____Annual Physical	____Return to Work	____Other: _____	____In-House Rapid (10 P	____Snellen (Vision Exam)
____DOT Physical	____Follow-Up		____Collection Only	____Ishihara (Color Blind Test)
____DOT Recertification	____Reasonable Suspi		____Hair Drug Screen	____OSHA Respirator Questior
____Fit for Duty	____Periodic Review		____Other:_____	____Respirator Fit Test
Other:	____Post Accident			____Chest X-Ray
				____EKG

IMMUNIZATION SERVICES AND LABORATORY TESTING

____PPD/Tuberculosis Skin Test - 1 - Step	____Vaccine - Influenza	____CBC	____ Post Exposure
____PPD/Tuberculosis Skin Test - 2 - Step	____Vaccine - Pneumonia	____CMP	Other Lab Services - Specify B
____Vaccine - Hep A: ___ 1st ___2nd (180 days)	Other Vaccines - Specify Below	____Urinalysis	_____
____Vaccine-Hep B:___1st___2nd(30 days)___3rd	_____	____Titer - Hepatitis A	_____
____Tetanus: ____TD ____Tdap	_____	____Titer - Hepatitis B	_____

Signature of Authorized Representative Date/Time