



## Employer Authorization for Examination or Treatment

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

Patient's Name \_\_\_\_\_

Date \_\_\_\_\_

Patient's SSN \_\_\_\_\_

DOB \_\_\_\_\_

**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

Employer Contact Email \_\_\_\_\_

Workers' Comp Carrier

**WORKERS' COMP CARRIER**

WC Carrier Name \_\_\_\_\_

Phone \_\_\_\_\_ Claim # \_\_\_\_\_

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