



EMPLOYER AUTHORIZATION FOR SERVICES

Westchase
11969 Sheldon Rd.
Tampa, FL 33626

South Tampa
3301 W. Gandy Blvd.
Tampa, FL 33611

Carrollwood
4505 Gunn Hwy.
Tampa, FL 33624

Wesley Chapel
5504 Gateway Blvd.
Wesley Chapel, FL 33544

Riverview
11406 US Hwy 301 S.
Riverview, FL 33578

Tyrone
3251 66th St. N.
St. Petersburg, FL 33710

Seminole
7601 Seminole Blvd.
Seminole, FL 33772

Employee Name: _____ Employee Date of Birth: _____

Employer Name: _____

Employer Phone Number: _____ Contact Name: _____

Existing Account: Yes No Would you like us to contact you to set up an account? Yes No

Choose Bill To

Employee Self Pay

Employer Paid Attention To: _____ Via (email, fax, mailing address): _____

Workers Compensation Carrier: _____ Contact Information: _____

Workers Compensation

Injury Treatment-Date of Injury: _____

Post-Accident Drug Testing (If urine drug screening is required, please complete section below)

WC Claim Number: _____

Insurance Used: _____

Post-Accident Alcohol Testing Breath Screen

Saliva Screen Other: _____

Physical Examination Needed

Select Type of Physical Required:

Pre-employment

DOT Physical

U.S. Coast Guard (Form Required)

None

Other: _____

Urine Drug Screening Needed

<p>Select Type of Screen Required (Select One Only):</p> <p><input type="checkbox"/> Rapid 5-panel <input type="checkbox"/> Rapid 10-panel</p> <p><input type="checkbox"/> DOT</p> <p><input type="checkbox"/> Traditional Non-DOT</p> <p> <input type="checkbox"/> Single Cup 5-panel <input type="checkbox"/> Single Cup 10-panel</p> <p> <input type="checkbox"/> Split Cup 5-panel <input type="checkbox"/> Split Cup 10-panel</p> <p><input type="checkbox"/> None</p>	<p>Select Reason for Screen:</p> <p><input type="checkbox"/> Pre-employment <input type="checkbox"/> Reasonable Suspicion/Cause</p> <p><input type="checkbox"/> Follow-up <input type="checkbox"/> Workers Compensation Injury</p> <p><input type="checkbox"/> Random <input type="checkbox"/> Return to Duty</p> <p><input type="checkbox"/> Other: _____</p>
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Titers Needed

Select Type:

Hepatitis A Hepatitis B

MMR Varicella

None

Other: _____

Vaccinations Needed

Select Type:

Hepatitis A Hepatitis B

MMR Varicella

Tetanus - TD PPD-TB

2-Step PPD None

Other: _____

Additional Services Needed

Select Type:

EKG Urinalysis

Chest X-Ray L-Spine X-Ray

Breath Alcohol Screening

None

Other: _____

I authorize Fast Track Urgent Care Center to treat the employee listed above for the services selected. Revised 3/2018©

Authorized Designated Employee Representative _____ Date _____

Fast Track Urgent Care Center reserves the right to refuse treatment without employer authorization. Services provided without proper authorization will be billed as the patient's responsibility. Services may vary by location. To confirm services and availability, please contact Fast Track Urgent Care Center at 813-925-1903.