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

☐ Downtown at The Heights
303 W Palm Ave
Tampa FL 33602

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

Select Type of Screen Required (Select One Only):

☐ Rapid 5-panel ☐ Rapid 10-panel

☐ DOT

☐ Traditional Non-DOT

☐ Single Cup 5-panel_ ☐ Single Cup 10-panel_

☐ Split Cup 5-panel ☐ Split Cup 10-panel

☐ None

Select Reason for Screen:

☐ Pre-employment ☐ Reasonable Suspicion/Cause

☐ Follow-up ☐ Workers Compensation Injury

☐ Random ☐ Return to Duty

☐ Other: ______________

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.