PromptMed™
URGENT CARE
Neighborhood Walk-In Medical Clinics

EMPLOYER AUTHORIZATION FORM

Please have your employee present this form upon check-in, or fax it ahead of time to the appropriate clinic number below.

COMPANY NAME: _____ **DATE OF REQUEST:** _____

EMPLOYEE NAME: _____ **THIS REQUEST EXPIRES AFTER:** _____

SOCIAL SECURITY # (required for work injury): _____ **EMPLOYEE PHONE #:** _____

** If a drug screen is needed, the employee must have a valid photo ID. If not able to provide an ID, the Direct Employer Representative (DER) will need to be present.*

WORK INJURY/ILLNESS

☐ Initial Injury Treatment

Date of Injury: _____

Description/Body Part: _____

☐ Injury Follow Up

DRUG & BREATH ALCOHOL TESTING (complete both sections)

1. Reason for Testing:

- □ Annual/Re-Certification
- □ Pre-Employment
- □ Post-Accident
- □ Random
- □ Return to Duty
- □ Reasonable Suspicion
- □ Other: _____

2. Type of Testing:

- □ Non-Federal
  - □ Urine Drug Test
    - □ 4-Panel (Excl. THC)
    - □ 5-Panel
    - □ 9-Panel (Excl. THC)
    - □ 10-Panel
  - □ Hair (7-Panel)
  - □ Breath Alcohol Test
- □ Federal/Department of Transportation (DOT)
  - □ Urine Drug Test
  - □ Breath Alcohol Test

PHYSICALS

- □ DOT Physical
- □ Pre-Placement
- □ Re-Certification
- □ Non-DOT Physical
- □ Illinois School Bus Driver Physical
- □ Wisconsin School Bus Driver Physical
- □ Pre-Employment
- □ Return to Work
- □ Respirator Physical (incl. PFT/Spirometry & OSHA)
- □ Asbestos Physical (incl. Chest X-Ray, PFT/Spirometry & OSHA)
- □ Other: _____

OTHER SERVICES

- □ Lift Test (_____lbs.)
- □ Respirator Mask Fit Test
- □ PFT/Spirometry
- □ Audiometry
- □ TB/PPD (Tuberculosis)

  * *Employee must return in 48-72 hours to have test read.*
- □ Other: _____

VACCINES

- □ Tetanus (Td / Tdap) Vaccination
- □ Flu Vaccination
- □ Hepatitis B Vaccination (3-Part Series) ____1 ____2 ____3
- □ Other: _____

Please check one of the boxes below:

- □ Bill the company's worker's compensation insurance carrier
- □ Bill the company directly
- □ Credit card or company check has been provided by the company to pay for services rendered
- □ Patient's responsibility to pay for services rendered

Please evaluate and treat above mentioned employee for current visit and any required follow up services needed. No services will be performed unless it is marked or unless your profile specifically states to do so.

Authorized by: _____ Title: _____

Date: _____ Phone: _____

Antioch 420 E. IL Route 173, Suite 101, Antioch, IL 60002 | Phone: 847.652.9700 | Fax: 847.652.9710
Grayslake 792 E. Belvidere Rd., Suite 300, Grayslake, IL 60030 | Phone: 224.371.6100 | Fax: 224.371.6110
Gurnee/Waukegan 724 N. Green Bay Rd., Waukegan, IL 60085 | Phone: 847.901.8400 | Fax: 847.901.8410
Highland Park 1849 Green Bay Rd., Suite 171, Highland Park, IL 60035 | Phone: 224.243.7600 | Fax: 224.243.7610
Hours of Operation Monday-Friday: 8:00AM – 8:00PM | Saturday & Sunday: 9:00AM – 5:00PM

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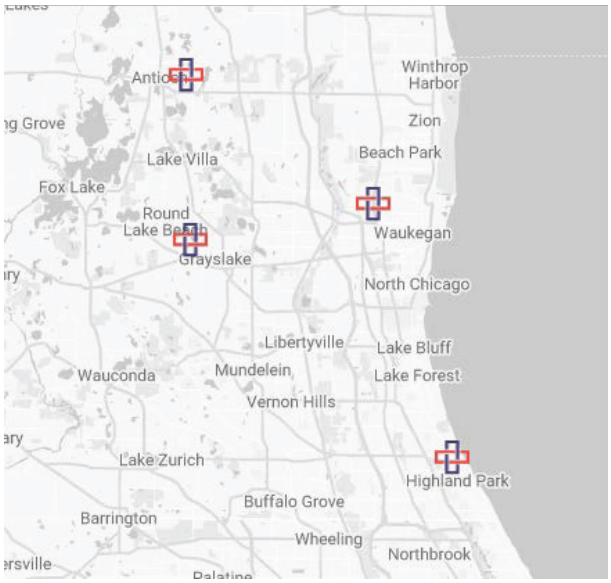

PromptMed Urgent Care - Antioch

420 E. IL Route 173
Suite 101
Antioch, IL 60002
Phone: 847.652.9700

PromptMed Urgent Care - Grayslake

792 E. Belvidere Rd.
Suite 300
Grayslake, IL 60030
Phone: 224.371.6100

PromptMed Urgent Care - Gurnee / Waukegan

724 North Green Bay Rd.
Waukegan, IL 60085
Phone: 847.901.8400

PromptMed Urgent Care - Highland Park

1849 Green Bay Rd.
Suite 171
Highland Park, IL 60035
Phone: 224.243.7600