



EMPLOYER'S AUTHORIZATION FOR EXAMINATION and/or TREATMENT

Employer must complete this form prior to the employee visit. **Employee** must present photo ID at time of service.

Employer Company Name Bulloch County Board of Commissioners	
Patient Name	Patient SSN/ID#
Employer Physical Address 115 N. Main Street, Statesboro, GA 30458	
Employer Billing Address 115 N. Main Street, Statesboro, GA 30458	
Employer PRIMARY Contact Name Thomas Capper	Employer PRIMARY Contact Title Risk Management Technician
Employer PRIMARY Work Phone (912)259-9707	Employer PRIMARY Mobile Phone
Employer PRIMARY Contact E-Mail HR@bullochcounty.net	Employer PRIMARY Contact Fax (912)764-4609
Employer PRIMARY Contact Best contact: <input type="checkbox"/> Work Phone <input type="checkbox"/> Mobile Phone <input checked="" type="checkbox"/> E-mail <input type="checkbox"/> Fax <input type="checkbox"/> Other:	
Employer DER Name: Thomas Capper	Employer DER Best Contact: tcapper@bullochcounty.net
Authorization Signature	Visit Date

BILLING INFORMATION

Bill EMPLOYER (see Employer Billing Address above)

EMPLOYEE to pay at time of Service

Bill WORKERS' COMPENSATION Insurance Company / TPA*:

Ins. Co. _____

Policy # _____

Address _____

Phone _____

Contact _____

Claim # _____

DRUG and ALCOHOL TESTING SERVICES

REASON FOR TESTING:

Post-Accident Random

Pre-employment Reasonable Suspicion

DOT New Certification DOT Recertification

TEST REQUIRED:

DOT Drug Screen Hair Follicle Testing

5-Panel Urine Screen Specimen Collection only

Instant Breath Alcohol Test

10-Panel Urine Screen

Instant Lab-based

WORK-RELATED INJURY CARE

Date of Injury: _____

Evaluate and Treat Light Duty is Available

Be sure to indicate Drug Screen and/or Breath Alcohol Test required under *DRUG and ALCOHOL TESTING SERVICES*

Are Drug Screens and/or Breath Alcohol Tests covered by Workers' Comp Ins Co/TPA?

Y N N/A

OCCUPATIONAL MEDICAL SERVICES

DOT Physical – New Certification

DOT Physical – Recertification

Non-DOT Physical (Standard)

Non-DOT Physical (Employer Provided)

Fit For Duty Evaluation (Physical + PPE)

Job Title/Desc _____

Audiogram

Pulmonary Function Test (PFT)

Chest X-Ray

Lumbar Spine X-Ray

EKG

TB Test

Nicotine Test

Flu Shot

Hepatitis Vaccine (circle) A B Both

Other _____

REPORTING RESULTS

Fax paperwork to employer

E-mail paperwork to employer

Call employer

Give all paperwork to employee

Give DOT card/Instant Screen Results Card only

SPECIAL INSTRUCTIONS

Please forward all results/documents to: HR@bullochcounty.net

AND tcapper@bullochcounty.net