St. Joseph's/Candler URGENT CARE

SOUTH GEORGIA IMMEDIATE CARE CENTER

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)764-0100	Employer PRIMARY Mobile Phone
Employer PRIMARY Contact E-Mail: SafetyFirst@bullochcounty.net	Employer PRIMARY Contact Fax: (912)764-4609
Employer PRIMARY Contact Best contact: ☐ Work Phone ☐ Mobile Phone ■ E-mail ☐ Fax ☐ 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*:

Contact ACCG Claims
TEL: 404.614.2553 | 877.421.6298
FAX: 678.225.4240 | 888.221.4079
EMAIL: accgclaimsmail@accg.org

Please mail all medical bills to:
CareWorks
ATTN: ACCGGSIWCF
2000 Malory Lane
Suite 130-324
Franklin, TN 37067

Claim # _____

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

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

_____

_____

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
  ☐ Lab-based
■ 10-Panel Urine Screen
  ■ Instant
  ☐ Lab-based

OCCUPATIONAL MEDICAL SERVICES

☐ DOT Physical – New Certification

☐ DOT Physical – Recertification

☐ Non-DOT Physical (Standard)

☐ Non-DOT Physical (Employer Provided)

☐ Fit For Duty Evalutaion (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 _____