ADVANCED URGENT CARE & OCCUPATIONAL MEDICINE
Phone: 303-659-9700 www.AdvUrgent.com

Employer Request and Authorization

(Information must be provided by a Designated Employer Representative (DER) or their C/TPA per 49 CFR 40.)

PLEASE BRING A VALID DRIVER'S LICENSE FOR ALL SERVICES

Date:_____ **Clinic Name:**_____

Patient/Donor Name:_____ **Date of Birth:**_____

Employer/Company Name:_____

Third Party Administrator Name (TPA) (if applicable):_____

Physical Examination

❒ Non DOT
❒ DOT Physical

Vaccinations/Tests

❒ Tetanus
❒ PPD/Tuberculosis

Worker's Compensation

❒ New Injury

Billing

❒ Bill to Worker's Compensation Insurance
❒ Direct Bill to Employer
❒ Employee to pay charges

Authorized DER Signature: _____

DER Phone Number: _____

Send Results To (Email Address or Fax Number):_____