Employer's Authorization Testing and/or Work Injury Treatment Form

(must have photo ID at time of service)

Patient Name: _____ **SSN/ID #:** _____ **DOB:** _____

Patient Address: _____ **Patient Phone #:** _____

Company: HR SERVICE PARTNERS **Co. Phone #:** 210-905-4372

Company Address: 8000 I-10 W Ste. 705 San Antonio, TX. 78230

Company Contact: Pete Delgado/Kathy Rodriguez **Email:** pete@hrspmail.com

Contact: Direct #: 210-756-5409 **Signature:** Pete Delgado **Date:** _____

Please attach job description if available.

Billing:

X **Employer (see address above)**

_____ **Employee to pay at time of service**

_____ **Workers Compensation (report injury to Ins. Co.)**

Ins. Co. _____

Address: _____

Phone #: _____

CLM #: _____

Pre-Employment Services: Yes or No

Urine Drug:

___ **DOT**

✓ **Non-DOT Instant Read**

___ **Non-DOT Send to Lab**

BAT:

___ **DOT**

___ **Non-DOT**

Physical: Yes or No

___ **DOT**

___ **Non-DOT**

___ **Specialty**

Work Injury Drug Testing: Yes or No ✓

Urine Drug:

___ **DOT**

✓ **Non-DOT Instant Read**

___ **Non-DOT Send to Lab**

BAT:

___ **DOT**

Work Related Injury Care:

___ **Non-DOT**

Date of Injury: _____

Job Title: _____

Description of incident & special instructions: _____

Email: worx@nlucc.com Phone: 832.706.2295 Fax: 832.706.2295