CLEARCHOICEMD®
URGENT CARE

Request for Medical Services

EMPLOYEE NAME:			
Company Name:			
Tel Number/ Fax Number:			
Employer Contact/Phone:			
SERVICES REQUESTED			
☐	WORK INJURY TREATMENT CLAIM NUMBER _____	☐	DOT PHYSICAL ☐ INITIAL ☐ RECERTIFICATION
☐	URINE DRUG SCREEN HAS CUSTODY AND CONTROL FORM? ☐ YES ☐NO	☐	RESP CLEARANCE EXAM
☐	PHYSICAL EXAMINATION	☐	BLOOD WORK (please list)
☐	OTHER SERVICES (please list)		

Special Instruction/Comments:

Authorized by: _____ Date:_____

Bill to: ☐ COMPANY ☐ EMPLOYEE ☐ WC CARRIER