



McMINNVILLE
IMMEDIATE HEALTH CARE
 & OCCUPATIONAL MEDICINE

SERVICE AUTHORIZATION

Employee/Patient Name: _____
 Date of Birth: _____ Employee ID#: _____
 Employer: _____
 Employer Address: _____
 Employer Contact/Phone: _____

Is injury/illness work related: yes no Date of Injury/Illness: _____
 Workers' Compensation Insurance: _____

Testing to be Done:

- Regulated (DOT) Drug Test Non-Regulated Drug Test
 Breath Alcohol Testing Urine Collection ONLY

Bill to: _____

Reason for Testing:

- Pre-Employment Random Follow-up Post Accident
 Reasonable Suspicion Other: _____

Physical Examinations:

- Pre-Placement CDL Annual
 Medical Surveillance DPSST Firefighter HAZMAT
 Respirator Exam Fit Test Spirometry Audio
 Lift Test Required Physical Capacity Required

Other: _____

Vaccinations/Immunizations:

- Hep B Hep A TDAP TB/PPD Influenza Titer For: _____
 Other: _____

Billing:

- Patient Pays All Charges Bill Employer Bill 3rd Party Admin

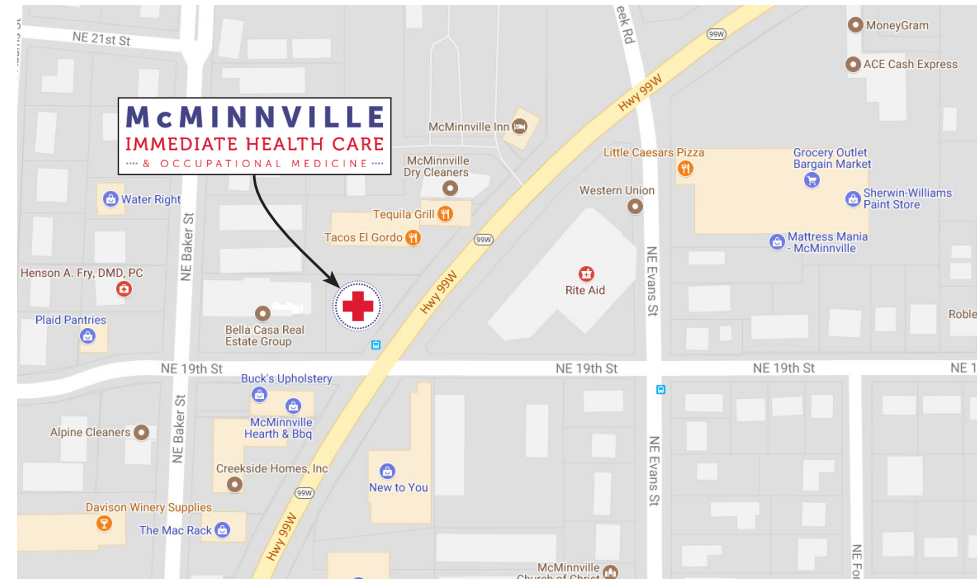
Authorized by: _____

Signature/Print/Title

Date of Request: _____

We offer more services. If you don't see it on the list or you have questions or need more info, PLEASE CALL PAMELA PATTANI at (503) 883-4445

Open Every Day Except Christmas



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Clinic Manager: Pamela.Pattani@mywvmc.com

NEW Extended Hours

Check our Website:

www.mcminnvillecare.com