◆ 100 US Highway 46 E, Ste 204, Mountain Lakes, NJ 07046 ◆ Tel (973) 917-3200 ◆ Fax (973) 917-3201
Open seven days a week. No appointment necessary ◆ MON 8-8, TUES - THURS 8-6, FRI 8-3, SAT & SUN 9-2.

Employer Authorization Form

Patient:_____ _____Date: _____/_____/_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Mobile Phone:_____

Employer:_____

Employers Address:_____City:_____State:_____Zip:_____

To The Patient: It is necessary for your employer or employer's representative to authorize your visit to Mountain Lakes Medical Center. Without their consent and signature, you will be held responsible for payment for any services rendered.

To The Employer: By signing this Authorization Form I authorize Mountain Lakes Medical Center to examine and treat this patient in any manner they deem appropriate. In the event of an injury, if the physician determines the injury is not job related, then the employer is responsible for any office visit fees necessary in making this determination. If submitting this claim to your insurance company, please call or fax us the claim number.

- O Treat a Work Related Injury (Date of Accident _____/_____/_____
- O Return to Work Status Examination
- O Pre-employment Examination
- O Drug Screening Reason for drug screen:_____
- O Physical, Non-Driver
- O Physical, Driver (DOT, CDL)
- O Respiratory Clearance
- O Other Testing or Evaluation:_____

Other comments or questions:_____

_____

_____

Authorized By:_____Date:_____/_____/_____

Title:_____

Phone Number: _____ Fax Number: _____