

◆ 100 US Highway 46 E, Ste 204, Mountain Lakes, NJ 07046 ◆ Tel (973) 917-3200 ◆ Fax (973) 917-3201
 ◆ website: mtlakesmedical@gmail.com MON - FRI 8am-3pm, SAT 8am-2pm.

## **Employer Authorization Form**

Patier Addre	tss:		Cit	State:	Date: _	// Zip:	
Phone	#:			Fax#:			
To The Patient:  To The Employer:		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.  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.					
0	Worker's Com	pensation:					
					Claim #:		
0	Return to Work Status Examination						
0	Drug Screen:		O Non - DOT (10 Panel)		O DOT (5 Panel)		
	Reason:		O Pre-Employment	O Random	<ul> <li>Return to Work</li> </ul>	O Other:	
0	Breath Alcoho	I Screening:	O Non - DOT	O DOT			
	Reason:		<ul> <li>Pre-Employment</li> </ul>	<ul><li>Random</li></ul>	<ul><li>Return to Work</li></ul>	Other:	
0	Physical:		O Pre-Employment	O DOT/CDL	<ul><li>Respirator</li><li>Clearance</li></ul>	O Other:	
0	COVID 19		O PCR	<ul> <li>Antibody</li> </ul>			
0	Other Testing	or Evaluation:					
Comm	ent or Question	ns:					
Employer: City:					Ctata		7in:
Phone	ss: e#:		CII	.y Fax#:	State: _		Zip:
Authorized By:							
Title: _ Phone				Fax#:			

"THIS FORM MUST BE PRESENTED AT TIME OF SERVICE"