# Treatment Authorization
## Autorización de Tratamiento

**Please present this form at front desk.** Presente este formulario en la recepción.
**For physical exams arrive at least 1 hour before closing.** Para los exámenes físicos, llegue al menos 1 hora antes del cierre

Name _____
Nombre

Injury Date _____
Fecha de la lesión

Employee Phone _____ REQUIRED
Teléfono del empleado

Email _____
Email

Employer _____
Empleador

Employer Phone _____
Teléfono del empleador

Insurance _____
Seguro de Compensación Laboral

Policy# _____
Número de Póliza

Is Modified Work Available? ☐ Yes Si ☐ No No
¿Está disponible el trabajo modificado?

Temporary Employee? ☐ Yes Si ☐ No No
¿Empleado temporal?

### OCCUPATIONAL TREATMENT REQUESTED TRATAMIENTO OCUPACIONAL SOLICITADO

☐ Work Related Injury Treatment ☐ Post Accident/Injury Drug Screen ☐ Return to Work Evaluation (Fitness for Duty)

### EMPLOYMENT RELATED EXAMINATION/TEST/IMMUNIZATIONS REQUESTED EMPLEO EXAMEN / PRUEBA / VACUNAS RELACIONADAS SOLICITADAS

| | | |
|---|---|---|
| ☐ DOT/DMV Physical | ☐ Employment Physical | ☐ RTW Physical |
| ☐ DOT Drug Screen | ☐ Drug Screen | ☐ Drug Screen Collection Only |
| ☐ Breath Alcohol Test | ☐ Hepatitis B Injection | ☐ Respirator Physical (OSHA) |
| ☐ Respirator Fit Test | ☐ Chest X-Ray | ☐ Pulmonary Function Test |
| ☐ Audio Test | ☐ Other _____ | |

Signature _____
Firma

Date _____
Fecha

☐ **Chula Vista Clinic**

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619.552.2870 P
619.768.2596 F

Regular Hours
Mon-Fri: 8:00am–6:00pm
Saturday: Closed
Sunday: Closed
Holidays: Closed
After Hours: Closed