



St. Francis
Urgent Care

EMPLOYER'S AUTHORIZATION FOR EXAMINATION AND TREATMENT FOR WORK RELATED INJURY

We are authorizing St. Francis Urgent Care Center to provide services to our employees:

LOCATED AT:

Address: 1649 Industrial Parkway West, Hayward, CA, 94544

Phone: (510)-780-9400

Fax: (510)-244-3655

Employer Name: _____

Employer Address: _____

PH: _____

Fax: _____

Employer # (if applicable): _____

Primary Contact Name: _____

PH: (after hrs) _____

Email: _____

EMPLOYEE DETAILS

DATE: _____ TIME: _____ AM OR _____ PM

PATIENT NAME: _____ DEPARTMENT: _____

DOES EMPLOYEE WORK FOR A TEMP/LEASING COMPANY? YES NO NAME OF TEMP AGENCY: _____

AUTHORIZED BY: NAME (PRINT): _____ PHONE: _____

TITLE: _____ AFTER HRS / CELL PH: _____

SIGNATURE: _____ () VERBAL

INSURANCE

INSURANCE COMPANY NAME: _____

CLAIMS ADDRESS: _____

PHONE#: _____ EFFECTIVE DATE: _____

POLICY #: _____ EXPIRATION DATE: _____

☐ INJURY: DATE OF INJURY: _____ LAST WORKED: _____

INJURED BODY PART: _____ CLAIM #: _____

☐ RETURN-TO-WORK EVALUATION _____

☐ PHYSICAL EXAM TYPE: _____ PROTOCOL #: _____