Glenside Medical Associates, P.C.

4000-A Glenside Drive
Richmond, VA 23228
(804) 262-4763
Fax (804) 262-6447

Hours
Mon – Fri: 8 a.m. – 3:30 p.m.

AUTHORIZATION FOR TREATMENT

DATE: _____ APPOINTMENT DATE:_____

PATIENT NAME: _____SS#_____

COMPANY NAME: _____

ADDRESS: _____

BILLING ADDRESS: _____

AUTHORIZED BY: _____

PHONE NUMBER: _____ FAX_____

FAX THE WORK RELEASE FORM WITH DX TO EMPLOYER IMMEDIATELY AFTER TREATMENT FAX#_____

TREATMENT REQUIRED

(PLEASE CHECK ALL REQUIRED)

☐ INJURY TREATMENT: _____
_____

☐ DOT PHYSICAL ☐ NEW CERTIFICATION ☐ RECERT

☐ PHYSICAL EXAM PHYSICAL TYPE: _____

PICTURE ID REQUIRED!

☐ URINE DRUG SCREEN ☐ DOT ☐ NON-DOT

☐ PRE-EMPLOYMENT ☐ RANDOM
☐ POST ACCIDENT/INJURY ☐ REASONABLE SUSPICION

☐ BREATH ALCOHOL TEST ☐ DOT ☐ NON-DOT

☐ RANDOM ☐ POST ACCIDENT/INJURY ☐ REASONABLE SUSPICION

OTHER (PLEASE SPECIFY)_____
