



Company: **RICHMOND COUNTY SCHOOL SYSTEM**

Phone#: **706-826-1000**

Date:

OCCUPATIONAL MEDICINE AUTHORIZATION

Employee Name	PD/TTER	Non-DOT							DOT							
		Physical	Drug Screen			Breath Alcohol			Physical	Drug Screen			Breath Alcohol			
			Random	Post Accident	Pre Emp	Random	Post Accident	Pre Emp		Random	Post Accident	Pre Emp	Random	Post Accident	Pre Emp	
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

WORKER'S COMPENSATION AUTHORIZATION-2030 Walton Way Office Only

Patient Name: _____

Insurance Company Name: **CHARLES TAYLOR, TPA**

Date of Birth: _____

Claim Adjustor's Name: _____

Date of Injury: _____

Claim Number: _____

Drug Screen Required: Yes No

Claims Address: **P.O. BOX 436499**

Employer Address: **864 BROAD STREET**
Augusta, GA 30901

LOUISVILLE, KY 40253

Claims Phone: **1-800-928-1342**

Claims Fax: **502-489-6430**

Authorized By: _____
Print Name

Signature

Title