

OCCUPATIONAL MEDICINE TREATMENT REFERRAL

Employee: _____ Date: _____

Employer: _____

Service Required: *(check all that apply)*

- Injury Treatment Pre-employment Physical DOT Physical
 DOT Drug Screen *(collection only)* Non-DOT Drug Screen Breath Alcohol Test

Other Service/Special Instructions:

SELECT CLINIC:

Call clinic to alert them of employee's arrival | Select appropriate clinic

BOISE

6051 W. Emerald St.
Phone: (208) 302-7600
Fax: (208) 302-7605

FRUITLAND

910 NW 16th St., Suite 102
Phone: (208) 452-8040
Fax: (208) 452-8056

CALDWELL

315 E. Elm St., Suite 100
Phone: (208) 302-7620
Fax: (208) 302-7192

NAMPA

1150 N. Sister Catherine Way
Phone: (208) 302-7640
Fax: (208) 302-7625

Referred by: _____

Contact #: _____

Occupational Medicine Provider Coverage

5 DAYS A WEEK AT ALL 4 CLINICS, 8AM-5PM

*Urgent Care extended hours available
at all above clinics*