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**
1906 Fairview Ave, St 430
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