Injured Worker Authorization Form
(Photo ID Required)

Employee Information

Full Name: ______________________________, SSN:__________________________, DOB:______________

Address:_______________________________, City:_________, State:___________, ZIP:_______________

Phone:______________________, Mobile:_____________________, Email:____________________________

Employer Information

Company Name: ______________________________, Authorized By:______________________________

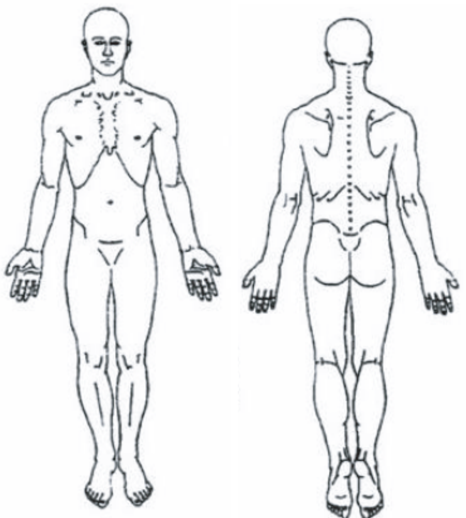
Title:_____________________________, Phone:____________________, Email:______________________

Company Address:_______________________________, City:_________, State:___________,

ZIP:_____________, Company Phone:______________________, Email:____________________________

Insurance Information

Insurance Provider: ______________________________, Claim Number:______________________________



(Circle Injured Body Part)

Injury Details

Brief Description of Injury:_________________________

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Date of the Injury:________________________________

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Please indicate whether or not we are authorized to perform post-accident drug screens, including Breath Alcohol Testing (BAT).

▢ **Post-Accident Drug Screen**

▢ **Breath Alcohol Testing (BAT)**

Location(s)

peakMEDIQ Occupational Medicine, LLC
Green Valley Ranch (Clinic)
4809 Argonne St., Ste. 150
Denver, CO 80249

Hours: 8AM-5PM, Monday thru Friday
Closed Weekends and Holidays

Phone: (720) 608-8255

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