EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT

(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

PATIENT NAME:____________________
COMPANY NAME:____________________
ADDRESS / LOCATION # :____________________
TEMPORARY STAFFING AGENCY:____________________

SSN:____________________
DATE OF BIRTH:____________________
DATE OF INJURY:____________________

WORK-RELATED

X INJURY ___ILLNESS

Post Accident Substance Abuse Testing:

X Drug Screen
___ Breath Alcohol
___ Urine Collection Only

TEST TYPE

___ DOT Regulated
X Non-Regulated

BILLING

___Bill company for services
___Employee to pay at time of service
___Bill Workers' Compensation Carrier

Carrier:____________________
Policy #:____________________
Phone #:____________________
Address:____________________

PHYSICAL EXAMINATIONS

Job Title:____________________

___ DOT Preplacement
___ DOT Recertification
___ Physical Exam
___ Asbestos
___ Respirator
___ Hazmat
___ Other____________________
___ HPE
___ Audiogram

TEST TYPE

___ Preplacement
___ Annual
___ Exit

SUBSTANCE ABUSE TESTING

___Regulated
___Non-Regulated
___Urine Collection Only
___Rapid Test
___eScreen
___Hair Collection
___Breath Alcohol

TEST TYPE

___Preplacement
___Random
___Reasonable Suspicion
___Post Accident
___Periodic
___Follow-up
___Return to Duty

Authorized By:____________________ Title:____________________

Phone:____________________ Date:____________________

C2902/3/4/7AUTH