



Authorization for Examination or Treatment

(Patient Must Present Photo ID at Time of Service)

Employer: _____

Today's Date: _____

Location: _____

Authorized By: _____

Employer Phone No.: _____

Employer Fax No: _____

Employee: _____

Employee Date of Birth: _____

Please check all that apply:

Work Injury/Illness

Date of Injury _____ Claim# (if available) _____

Physical Examination

Pre-placement DOT Periodic/Annual Exit Return to Work Fitness for Duty

Respirator Clearance Asbestos Hazmat Medical Surveillance Other: _____

Substance Abuse Testing

Federally regulated drug screen Non-regulated drug screen Collection only

Breath Alcohol Hair Test 10 panel 5 panel Rapid 10 panel

Rapid 5 panel Other: _____

Reason for Substance Abuse Testing

Pre-placement Reasonable Cause Post-accident Random Follow-up

Other Services

Respirator Fit Test Audiogram PPD Pulmonary Function Test EKG Chest x-ray

Vaccination: _____ Other: _____

Special instructions/comments: _____

