

**EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT
(MUST PRESENT PHOTO ID AT TIME OF SERVICE)**

Patient Name _____

Address _____ City _____ State _____ Zip Code _____

SSN _____ Date of Birth _____ Date of Injury _____

Please check the tests to be performed under the corresponding section

Work Related Injury Illness

- Post-accident drug screening
- Drug Screen
- Alcohol Saliva Test
- Drug Screen and Alcohol Saliva Test
- Urine Collection Only

- DOT Regulated

DOT Physical

- Pre-placement
- Recertification
- Exit
- Audiogram
- Regulated Drug Screen
- Urine Collection Only
- Alcohol Saliva Test

Pre-Placement Evaluation

- Job Title _____
- Physical Exam
 - Regulated Drug Screen
 - Non-Regulated Drug Screen
 - Urine Collection Only

Substance Abuse Testing

- Regulated
- Non-Regulated
- Urine Collection Only
- Pre-Placement
- Reasonable Suspicion
- Random
- Periodic
- Post-accident
- Follow-up
- Alcohol Saliva Test

Special Physical Examinations

- DOT
- Respirator
- Baseline

Billing Information:

- Bill Employer Employee to pay charges at time of service Workers Compensation

Billing Address for Services

Insurance Company _____

Address _____ City _____ State _____ Zip Code _____

Policy Number _____ Phone _____ Fax Number _____

Authorized by:

Name _____ Title _____

Phone _____ Date _____