



AUTHORIZATION FOR EXAMINATION OR TREATMENT

Patient Name: _____ S.S. #: _____ - _____ - _____

Employer: _____ Date of Birth: _____

Work Related

- Injury Illness

Date of Injury _____

Substance Abuse Testing (check all that apply)

- DOT Drug Test Urine Alcohol
 DRUG 5 Breath Alcohol
 DRUG 9 Quick Screen _____

Type of Substance Abuse Testing

- Pre-Employment Reasonable Cause Post Accident
 Random Periodic Follow-Up
 Return to Duty

Physical Examination

- Preplacement Baseline Annual Exit

DOT Physical Examination

- Preplacement Recertification Exit

Special Examination

- Respiratory Fit Test Audiogram
 Blood Work _____

Billing (check if applicable)

- Employee to pay charges

Special Instructions/Comments: _____

Authorized By: _____

Signature

Print

Phone: (_____) _____

Date