EMPLOYERS AUTHORIZATION FOR EXAMINATION OR TREATMENT

(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

Patient Name: _____ SSN: _____

Company Name: _____ DOB: _____

Address/Location#: _____ Date of Injury: _____

PHYSICAL EXAMINATIONS

Job Title: _____

___ CDL Physical ___ Worker's Compensation (Insurance Carrier info req.) ___ Pre-Employment

___ Other: ___ Post Accident

SUBSTANCE ABUSE TESTING

___ DOT Regulated Urine Drug Screen

___ Non-Regulated Urine Drug Screen ___ Rapid test 5 Panel (Non-Regulated ONLY)

___ Breath Alcohol Test

TEST TYPE

___ Pre-Employement ___ Random

___ Reasonable Suspicion ___ Post Accident

___ Periodic ___ Return to Duty

___ Other : _____

BILLING

___ Bill Company ___ Employee to pay at time of service

___ Bill Worker's Compensation Carrier _____

Policy _____

Phone # _____

Address: _____

Authorized By: _____ Title: _____

Phone: _____ Date: _____