



**Authorization for Examination or Treatment**

*(Patient Must Present Photo ID at Time of Service)*

**Company Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Company Contact:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Employee Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

*Please check all that apply:*

**Work Injury/Workers Compensation**

Date of Injury: \_\_\_\_\_ Claim# (if available): \_\_\_\_\_

Injury Description: \_\_\_\_\_

**Physical Examination**

- Pre-placement     DOT     Periodic/Annual     Exit     Return to Work     Fitness for Duty
- Respirator Clearance     Respirator Questionnaire Review Only     Hazmat (Include details below)
- Other: \_\_\_\_\_ Physical Instructions: \_\_\_\_\_

**Substance Abuse Testing**

- DOT     5 Panel     10 Panel     Rapid 5 Panel     Rapid 10 panel     Alcohol Saliva
- Breath Alcohol     Other: \_\_\_\_\_
- Collection only—Lab Name: \_\_\_\_\_ Chain of Custody:  Yes     No

**Reason for Substance Abuse Testing**

- Pre-placement     Post-accident     Random     Reasonable Cause

**Other Services**

- Respirator Fit Test     Audiogram     PPD     Pulmonary Function Test     EKG     Chest x-ray
- Vaccinations: \_\_\_\_\_  Blood Work: \_\_\_\_\_
- Other: \_\_\_\_\_

**Special Instructions/Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Authorized By:** \_\_\_\_\_ **Signature:** \_\_\_\_\_