Treatment Authorization Form

Please complete form and sign to authorize treatment.

Employee Name: _____ Date: _____

Name of Employer: _____ Phone: _____

Authorized by: _____ Date: _____

Date of Injury: _____ Type of Injury: _____

Claim #: _____

If Insurance information has changed please complete section below:

Insurance Company: _____

Policy Number: _____ Effective Date: _____

Occupational Medicine Services Post Accident :

Drug Screen: Yes or No

Drug Screen Type:

5 Panel or 10 Panel

- DOT
- Non-DOT
- Quick Test
- Hair Test
- Drug Free Workplace

Alcohol Testing:

- DOT Breath Alcohol Test
- Non-DOT Breath Alcohol Test

Medical Screening Request

Please have your employee bring this form with them or complete on line

Physicals (Please Check one)

- Pre-placement
- Return to work
- Annual Physical
- DOT Physical: Pre-placement or Recertification

Drug Screen: Type: 5-panel or 10-panel

- DOT
- Non DOT
- Quick Test
- Hair Test
- Pre-employment
- Random
- Return to Work
- For Cause
- Collection Only

Alcohol Testing: DOT or Non DOT

Other Services:

Tetanus Shot Hepatitis B (series of 3) Vision Test _____

TB Test Hearing Test Other: