## Employer's Authorization for Examination and/or Treatment

**Employer** to complete prior to employee visit. **Employee** must present valid photo ID at time of service.

Employer Company Name: _____
Patient's Name: _____ Patient SSN/ID#: _____
Employer Physical Address: _____
Employer Billing Address: _____
Contact Name: _____ Contact Title: _____
Contact Work Phone: _____ Contact Mobile Phone: _____
Contact Email: _____ Contact Fax: _____
Best Form of Contact: ( ) Work Phone ( ) Mobile Phone ( ) Fax ( ) Other: _____

Authorization Signature: _____ Date of Visit: _____

**Billing Information:**

- ☐ Bill Employer (See employer billing address above)
- ☐ Employee to pay at time of service
- ☐ Bill Worker's Compensation Insurance Company/TPA:
  Ins. Company: _____
  Policy #: _____
  Address: _____
  Phone: _____
  Contact: _____
  Claim #: _____

**Drug and Alcohol Testing Services:**

Reason for testing: (circle one)

- Post-Accident, Pre-Employment, Random, Reasonable Suspicion, DOT Certification, DOT Recertification

**Testing Required:**

- ☐ Specimen Collection Only
- ☐ DOT Drug Screen
- ☐ 5-Panel: (circle) Instant or Lab-based
- ☐ 10-Panel: (circle) Instant or Lab-based
- ☐ Hair Follicle Testing
- ☐ Breath Alcohol Testing

**Work-Related Injury Care**

Date of Injury: _____

- ☐ Evaluate and Treat
- ☐ Light Duty is Available

Are Drug Screens and/or Breath Alcohol Tests covered by Worker's Comp Ins. Co/TPA?

- ☐ Yes
- ☐ No
- ☐ N/A

**How would you like to receive paperwork/communication?**

**____ Fax ____ Email ____ Give copy to employee**

**Occupational Medical Services**

- ☐ DOT Physical—New Certification
- ☐ DOT Physical—Recertification
- ☐ Non-DOT Physical (Standard Physical)
- ☐ Non-DOT Physical (Employer provided)
- ☐ Fit for Duty Evaluation (Physical + PPE)
  - Job Title: _____
- ☐ Audiogram
- ☐ Pulmonary Function Test (PFT)
- ☐ Chest X-Ray
- ☐ Lumbar Spine X-Ray
- ☐ EKG
- ☐ TB Test
- ☐ Flu Vaccine
- ☐ Hepatitis Vaccine(circle) A B Both
- ☐ Other: _____

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