



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
- ☐ 5(*)

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
- ☐ "6
- ☐ TB Test
- ☐ Flu Vaccine
- ☐ Hepatitis Vaccine (circle) A B Both
- ☐ Other: _____