



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: _____	

<p>Billing Information:</p> <p>☐ Bill Employer (See employer billing address above)</p> <p>☐ Employee to pay at time of service</p> <p>☐ Bill Worker's Compensation Ins. Co/TPA:</p> <p>Ins. Company: _____</p> <p>Policy #: _____</p> <p>Address: _____</p> <p>Phone: _____</p> <p>Contact: _____</p> <p>Claim #: _____</p>	<p>Drug and Alcohol Testing Services:</p> <p>Reason for testing: (circle one)</p> <p>▪ Post-Accident, Pre-Employment, Random, Reasonable Suspicion, DOT Certification, DOT Recertification</p> <p>Testing Required:</p> <p>☐ Specimen Collection Only</p> <p>☐ DOT Drug Screen</p> <p>☐ 5-Panel: (circle) Instant or Lab-based</p> <p>☐ 10-Panel: (circle) Instant or Lab-based</p> <p>☐ Hair Follicle Testing</p> <p>☐ Breath Alcohol Testing</p>
<p>Work-Related Injury Care</p> <p>Date of Injury: _____</p> <p>☐ Evaluate and Treat</p> <p>☐ Light Duty is Available</p> <p>Are Drug Screens and/or Breath Alcohol Tests covered by Worker's Comp Ins. Co/TPA?</p> <p>☐ Yes</p> <p>☐ No</p> <p>☐ N/A</p> <p>How would you like to receive paperwork/communication?</p> <p>____ Fax ____ Email ____ Give copy to employee</p>	<p>Occupational Medical Services</p> <p>☐ DOT Physical—New Certification</p> <p>☐ DOT Physical—Recertification</p> <p>☐ Non-DOT Physical (Standard Physical)</p> <p>☐ Non-DOT Physical (Employer provided)</p> <p>☐ Fit for Duty Evaluation (Physical + PPE)</p> <p>Job Title: _____</p> <p>☐ Audiogram</p> <p>☐ Pulmonary Function Test (PFT)</p> <p>☐ Chest X-Ray</p> <p>☐ Lumbar Spine X-Ray</p> <p>☐ EKG</p> <p>☐ TB Test</p> <p>☐ Flu Vaccine</p> <p>☐ Hepatitis Vaccine (circle) A B Both</p> <p>☐ Other: _____</p>

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