



Patient Label

AUTHORIZATION FOR SERVICES

Company Name: _____ Company Phone: _____

Designated Employee Representative (Please print): _____

Alternate Contact (Please print): _____

Designee Phone: _____ Designee Fax: _____

Employee Name: _____ Social Security Number: _____

Job Title: _____ Department: _____

Injury

Type of Injury: _____

Date Injury Occurred: _____ Time Injury Occurred: _____ AM/PM

Physicals

- New Hire Exam
- Return to Work Exam
- Respirator Clearance Exam
- Other: _____
- DOT/CDL Exam
- Chauffeur Exam
- PIV (Powered Industrial Vehicle) Exam
- FAA Exam

Other Services

- Vaccine: _____
- Titer (Immune Status Check): _____
- Other: _____
- Tuberculin Skin Test
- Audiogram
 - Baseline Annual Retest

Substance Abuse Test Requested (Photo ID Required)

- Regulated (DOT) Non-Regulated
- Urine Drug Screen
- Breath Alcohol Test
- Breath Test and Urine Drug Screen

Purpose of Test (Photo ID Required)

- Reasonable Suspicion/Just Cause
- Random
- Random - Rehab Program
- Post Accident
- New Hire
- Other: _____

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Hours of Operation
Monday - Thursday | 8 AM to 4 PM

