

Authorization for Examination or Treatment



Please check off services needed for your employee's visit.

Patient Information:

Company Name:	Date of Birth:	I.C. #:
Patient Name:	SS#:	

Work Related:

<input type="checkbox"/> Injury	<input type="checkbox"/> Illness	Date of Injury _____
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Physical Examination:

DOT: <input type="checkbox"/> Pre-employment	<input type="checkbox"/> Recertification	NON-DOT: <input type="checkbox"/> Pre-employment
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Substance Abuse Testing:

Urine Drug Screens:

- DOT (5-panel)
- Non-DOT (10-panel)
- Instant Drug Screen (5-panel)

Alcohol Screens:

- Breath test (EBT)
- Blood test

Special Procedures:

- PPD Placement
- Chest X-ray
- Hepatitis B
- Flu vaccination
- Other _____

Special Instruction /Comments

Authorization:

Phone:	Date:
Printed Name:	Signature: