

EMPLOYER'S AUTHORIZATION for EXAMINATION or TREATMENT
(You must present PHOTO ID at time of Service)

Employee/Candidate Name: _____ Date: _____

Company Name: _____

STAT call results to: _____ Phone () _____ - _____ Fax () _____ - _____

Temporary Staffing Agency: _____ (if applicable)

<p>Pre-Placement/Post Offer Evaluation Job Title: _____</p> <p>_____ Physical Exam _____ Special Physical Exam: _____ Other: _____</p> <hr/> <p>DOT/19A Physical Examination</p> <p>_____ Pre-Employment-DOT _____ Re-Certification-DOT _____ 19A Exam _____ 19A/DOT Exam Combo</p> <p>_____ Give Card to Driver _____ Mail Card</p> <hr/> <p>Substance Abuse Testing</p> <p>_____ DOT Drug Test _____ non-DOT Drug Test _____ Rapid/Instant</p> <p>_____ Breath Alcohol: DOT _____ Breath Alcohol: non-DOT</p> <p>_____ Pre-Placement _____ Random _____ Post Accident _____ Periodic _____ Reasonable Suspicion _____ Return to Work</p> <p>_____ Hair _____ Collection Only</p> <p>_____ Other Test: _____</p>	<p>Workers Comp / Work Related Injury/Illness/Accident</p> <p>Please check the service(s) that are to be performed:</p> <p>_____ Injury/Illness/Accident Medical Evaluation & Treatment _____ Drug Screening _____ Breath Alcohol _____ Both Drug Screen and Breath Alcohol Testing _____ Urine Collection Only</p> <p>_____ DOT _____ Non-DOT</p> <hr/> <p>Special Physical Examinations Job Title: _____</p> <p>_____ Respirator Clearance Examination _____ Asbestos Exam _____ Hazmat Exam _____ Firefighter Exam _____ Other _____</p> <hr/> <p>Check One:</p> <p>_____ Baseline/ Initial _____ Annual _____ Periodic</p> <hr/> <p>Other Testing/Services</p> <p>_____ Fitness for Duty/Return to Work Exam _____ OSHA Respirator Questionnaire _____ Fit Test: Qualitative or Quantitative by PortaCount _____ Pulmonary Function Test _____ Vision Screening Only _____ Audiogram Only _____ X-ray _____ 1View _____ 2 View _____ B-reader _____ Photo ID _____ Other _____</p>
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BILLING INFORMATION

Bill Company Bill Worker's Compensation Insurance Carrier _____
Insurance Carrier Phone # _____

EMPLOYEE TO PAY FOR CHARGES AT TIME OF SERVICE

Authorized By: _____ Title: _____

Phone #: _____ FAX #: _____ Date: _____