CareSpot Express Healthcare

Authorization for Occupational Health Services

This is authorization to examine or treat: *(applicant or employee name)*	**Date:**
Authorization Signature: *(required)*	**Authorizer Name:** *(print)*
Company Contact:	**Company Name:**
Phone:	**Fax:**
Billing Address:	
WC Insuruer:	**WC Adjuster:**
Phone:	**Fax:**

Services Requested

Workers' Compensation Claim Medical treatment of injury or exposure. Please describe:

_____

_____

Is Alternative work available? ○ Yes ◉ No Fax Return to Work form to: _____

Drug Free Workplace Testing (ID required)

Choose one:

- ☐ DOT 7-panel *(must specify testing authority agency below)*
- ☐ DOT Breath Alcohol
- ☐ FL DFW 5-panel
- ☐ FL DFW 8-panel
- ☐ FL DFW 9-panel
- ☐ FL DFW 10-panel
- ☐ SAP 10-panel
- ☐ _____

- ☐ Blood Alcohol
- ☐ Hair Testing
- ☐ Instant
- ☐ eScreen
- ☐ Saliva

Also Choose:

- ☐ Pre-employment
- ☐ Post-accident
- ☐ Return to work
- ☐ For-cause
- ☐ Random
- ☐ Collection Only: _____

Physical Examination

- ☐ Basic Employment Physical
- ☐ Intermediate Employment Physical
- ☐ Executive Employment Physical
- ☐ OSHA surveillance
  - ☐ Respirator clearance
  - ☐ Other: _____
- ☐ DOT certificate
- ☐ Fitness-for-duty
- ☐ International travel
- ☐ Independent medical
- ☐ Evaluation
- ☐ Other: _____

Vaccines and Ancillary Service

- ☐ Tuberculosis test
- ☐ Laboratory: _____
- ☐ Vaccination:
  - ☐ Tetanus / Tdap ☐ Hepatitis A
  - ☐ Flu ☐ Hepatitis B
  - ☐ Other: _____
- ☐ Urine analysis
- ☐ EKG (heart)
- ☐ Spirometry (lungs)
- ☐ X-ray w/ written referral
- ☐ X-ray w/ office visit for physician referral
- ☐ Other: _____

Testing Authority Agency: *(required for DOT 7-panel)* ☐ HHS ☐ NRC ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG