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