

Authorization for Occupational Health Services

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

Services Requested

Workers' Compensation Claim		Medical treatment of injury or exposure. Please describe:	
<hr/> <hr/>			
Is Alternative work available? <input type="checkbox"/> Yes <input type="checkbox"/> No		Fax Return to Work form to: _____	
Drug Free Workplace Testing (ID required) Choose one: <input type="checkbox"/> DOT 7-panel <i>(must specify testing authority agency below)</i> <input type="checkbox"/> DOT Breath Alcohol <input type="checkbox"/> FL DFW 5-panel <input type="checkbox"/> FL DFW 8-panel <input type="checkbox"/> FL DFW 9-panel <input type="checkbox"/> FL DFW 10-panel <input type="checkbox"/> SAP 10-panel <input type="checkbox"/> _____ <input type="checkbox"/> Blood Alcohol <input type="checkbox"/> Hair Testing <input type="checkbox"/> Instant <input type="checkbox"/> eScreen <input type="checkbox"/> Saliva Also Choose: <input type="checkbox"/> Pre-employment <input type="checkbox"/> Post-accident <input type="checkbox"/> Return to work <input type="checkbox"/> For-cause <input type="checkbox"/> Random <input type="checkbox"/> Collection Only: _____	Physical Examination <input type="checkbox"/> Basic Employment Physical <input type="checkbox"/> Intermediate Employment Physical <input type="checkbox"/> Executive Employment Physical <input type="checkbox"/> OSHA surveillance <input type="checkbox"/> Respirator clearance <input type="checkbox"/> Other: _____ <input type="checkbox"/> DOT certificate <input type="checkbox"/> Fitness-for-duty <input type="checkbox"/> International travel <input type="checkbox"/> Independent medical <input type="checkbox"/> Evaluation <input type="checkbox"/> Other: _____	Vaccines and Ancillary Service <input type="checkbox"/> Tuberculosis test <input type="checkbox"/> Laboratory: _____ <input type="checkbox"/> Vaccination: <input type="checkbox"/> Tetanus / Tdap <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Flu <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Other: _____ <input type="checkbox"/> Urine analysis <input type="checkbox"/> EKG (heart) <input type="checkbox"/> Spirometry (lungs) <input type="checkbox"/> X-ray w/ written referral <input type="checkbox"/> X-ray w/ office visit for physician referral <input type="checkbox"/> Other: _____	
Testing Authority Agency: <input type="checkbox"/> HHS <input type="checkbox"/> NRC <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG <i>(required for DOT 7-panel)</i>			