



Employer's Authorization for Examination or Treatment

(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

Patient Name: _____ SSN: _____

Company Name: _____ Date of Birth: _____

Location #/Street Address: _____ Date of Injury: _____

Temporary Staffing Agency: _____

WORK-RELATED _____ INJURY _____ ILLNESS _____

Post-Accident Substance Abuse Testing:

- Drug Screen
- Breath Alcohol
- Drug Screen and Breath Alcohol
- Urine Collection Only

- DOT Regulated
- Non-regulated

DOT PHYSICAL

- Preplacement
- Recertification
- Exit
- Audiogram
- Regulated Drug Screen
- Urine Collection Only
- Breath Alcohol

PRE-PLACEMENT EVALUATION

Job Title: _____

- Physical Exam
- HPE
- Regulated Drug Screen
- Non-regulated Drug Screen
- Urine Collection Only
- Hair Collection
- Audiogram

SUBSTANCE ABUSE TESTING

- Regulated
- Non-regulated
- Urine Collection Only
- Rapid Test
- Pre-placement
- Reasonable Suspicion
- Random
- Periodic
- Post-accident
- Follow-up
- Breath Alcohol

SPECIAL PHYSICAL EXAMINATIONS

- Asbestos
- Respirator
- Hazmat
- Baseline
- Other _____

BILLING

- Employee to pay charges at time of service
- Workers' Compensation
- Insurance Co: _____
- Policy #: _____
- Phone #: _____

Authorized By: _____ Title: _____

Phone: _____ Date: _____

(copies of this form available at www.concentrahealth.com)