Grand View Hospital Campus
4 Lifemark Drive
Sellersville, PA 18960
P: 215.453.4941 | F: 215.453.4719

GVH GRAND VIEW HEALTH
WORKPLACE HEALTH & WELLNESS

Harleysville Outpatient Center
270 Main Street, Suite 2
Harleysville, PA 19438
P: 215.453.4941 | F: 215.453.4719

EMPLOYER AUTHORIZATION FOR TREATMENT FORM

(Complete and present at the time of service)

Applicant/Employee Name:	**DOB:**
Does employee work for a temp agency? ☐ **YES** ☐ **NO**	**Name of Temp Agency:**

EMPLOYER INFORMATION

DER/Company contact for confidential drug/alcohol test results:			
Company Name:			
Company Address:			
Company City:		**State:**	**Zip:**
Phone:	**Fax:**	**Email:**	

Billing/Workers' Compensation Claim Information:

☐ **Company Billing Address** *(only if different than above)*

Address: ______ City: ______ State: ______ Zip: ______

☐ **WC Insurance Carrier**: ______

Address: ______ City: ______ State: ______ Zip: ______

Claim #: ______ Adjuster's Name: ______ Phone: ______

Please provide the employee with the following services: *(please check all that apply)*

Work Related:

- ☐ Workers' Compensation Injury and/or Illness Treatment
- ☐ DOT Physical/Medical Card Exam
- ☐ Pre-Employment/Post-Offer Physical (NDOT)
- ☐ Fitness-for-Duty Physical ***(employer will provide job description)***
- ☐ Return-to-Work Physical ***(employer will provide job description)***
- ☐ Respirator Clearance Physical (OSHA Questionnaire Review)
- ☐ Special Company Physical Form ***(employer will provide form)***
- ☐ Audiogram
- ☐ Pulmonary Function Test / Spirometry
- ☐ Lift Test
- ☐ Qualitative Fit Testing ***(must provide own masks)***
- ☐ Vaccines
  - ☐ Flu ☐ Hep A ☐ Hep B ☐ PPD (1-step)
  - ☐ Td ☐ Tdap ☐ Twinrix ☐ PPD (2-step)
  - ☐ Other: ______

Drug and/or Alcohol Testing: (PHOTO ID IS REQUIRED FOR TESTING)

☐ **DOT Urine Drug Screen*** *(5-panel/check agency below)*
- ☐ FMCSA ☐ FAA ☐ FRA
- ☐ FTA ☐ PHMSA ☐ USCG

☐ **NDOT Urine Drug Screen***
- ☐ 5-Panel ☐ 7-Panel ☐ 10-Panel
- ☐ Other: ______

☐ **Collection Only-UDS (you must supply Chain of Custody)**

☐ **Breath Alcohol Test***
- ☐ DOT
- ☐ NDOT ______

(DOT cutoff level of 0.02 used for NDOT unless otherwise stated)

☐ **Hair Drug Screen**
(Collection Only – you must supply Chain of Custody & Kit)

*Drug and alcohol testing procedures will follow the federal guidelines as established by the Department of Transportation unless otherwise stated.

Company Specific Protocol:

Reason for Drug/Alcohol Testing: (please check one)

- ☐ Pre-Employment ☐ Random ☐ Reasonable Suspicion ☐ Follow-Up
- ☐ Return to Duty ☐ Post-Accident ☐ Other: (specify)______

Employee's Appointment Information (Applicant/Employee must present photo ID at time of service)

Date: ______ **Time:** ______ **Location:** Sellersville **OR** Harleysville

This certifies that the above information is correct. I authorize the medical provider to provide medical treatment to the employee named above. I also understand that the services provided will be paid in full by the company listed above and authorized by my signature below.

Employer Signature: ______ Date: ______

Print Name & Title: ______ Phone: ______