

EMPLOYER AUTHORIZATION FOR TREATMENT FORM

(Complete and present at the time of service)

Applicant/Employee Name:		DOB:
Does employee work for a temp agency? <input type="checkbox"/> YES <input type="checkbox"/> NO	Name of Temp Agency:	

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

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

<input type="checkbox"/> DOT Urine Drug Screen* (5-panel/check agency below) <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG <input type="checkbox"/> NDOT Urine Drug Screen* <input type="checkbox"/> 5-Panel <input type="checkbox"/> 7-Panel <input type="checkbox"/> 10-Panel <input type="checkbox"/> Other: _____ <input type="checkbox"/> Collection Only-UDS (you must supply Chain of Custody)	<input type="checkbox"/> Breath Alcohol Test* <input type="checkbox"/> DOT <input type="checkbox"/> NDOT _____ (DOT cutoff level of 0.02 used for NDOT unless otherwise stated)	<input type="checkbox"/> 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)

<input type="checkbox"/> Pre-Employment	<input type="checkbox"/> Random	<input type="checkbox"/> Reasonable Suspicion	<input type="checkbox"/> Follow-Up
<input type="checkbox"/> Return to Duty	<input type="checkbox"/> Post-Accident	<input type="checkbox"/> Other: (specify) _____	

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

Date: _____ Time: _____ Location: Sellersville OR Harleysville OR Chalfont

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: _____