

**AUTHORIZATION FOR MEDICAL SERVICES**

COMPANY NAME		EMPLOYEE'S NAME	
IF TEMPORARY EMPLOYEE – NAME OF TEMPORARY AGENCY			
AUTHORIZED BY (SIGNATURE)		DATE SIGNED	PRINTED NAME
TITLE		PHONE NO.	
_____ Work-Related Injury		Date of Injury: _____	

**PHYSICAL EXAMS** Check examination requested. Please request any other testing below.

- \_\_\_\_\_ Post-offer Exam (Send job description if available)
- \_\_\_\_\_ DOT Exam – New certification **CDL** \_\_\_ **Non-CDL Physical Card Only** \_\_\_
- \_\_\_\_\_ DOT Exam Re-certification **CDL** \_\_\_ **Non-CDL Physical Card Only** \_\_\_
- \_\_\_\_\_ Travel Clinic
- \_\_\_\_\_ FAA Physical
- \_\_\_\_\_ School Bus Physical
- \_\_\_\_\_ Respirator Examination
- \_\_\_\_\_ Driving School Instructor Physical
- \_\_\_\_\_ Medical Surveillance Exam – Initial / Baseline: Type of exposure \_\_\_\_\_
- \_\_\_\_\_ Medical Surveillance Exam – Annual / Interim: Type of exposure \_\_\_\_\_
- \_\_\_\_\_ WorkSteps Exam
- \_\_\_\_\_ Other: \_\_\_\_\_

**OTHER TESTING**

- \_\_\_\_\_ Hearing Test (audiogram) \_\_\_\_\_ Chest X-Ray \_\_\_ 1 View \_\_\_ 2 View
- \_\_\_\_\_ Titmus Vision \_\_\_\_\_ Urinalysis
- \_\_\_\_\_ Pulmonary Function Test (spirometry)
- \_\_\_\_\_ Respirator Fit Testing - Quantitative
- \_\_\_\_\_ Respirator Fit Testing - Qualitative
- \_\_\_\_\_ Lab (Specify) \_\_\_\_\_

**IMMUNIZATIONS/VACCINATIONS**

- \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Hepatitis A \_\_\_\_\_ Twinrix (HepA&B Combo)
- \_\_\_\_\_ Tetanus \_\_\_\_\_ Typhoid
- \_\_\_\_\_ TB Skin Test (PPD) \_\_\_\_\_ Flu Vaccine
- \_\_\_\_\_ Other (specify) \_\_\_\_\_

**SUBSTANCE ABUSE TESTING (Must have photo ID) Check type of test(s) and reason for test**

**TEST REQUIRED:**

**REASON FOR TEST:**

- |   |                                |
|---|--------------------------------|
| _____ Urine Drug Screen w/MRO - DOT**           | _____ Pre-placement/Post Offer |
| _____ Urine Drug Screen w/MRO – Non DOT         | _____ Reasonable cause         |
| _____ Urine Drug Screen – Collection Only       | _____ Follow-up                |
| _____ Instant Drug Screen (pre-employment only) | _____ Random                   |
| _____ Breath Alcohol Test – DOT                 | _____ Post Accident            |
| _____ Breath Alcohol – Non DOT                  | _____ Return to Duty           |

\*\*For Federal Drug Testing, please specify Testing Authority:

- HHS     NRC  
 DOT - Please Specify DOT Agency:  FMCSA  FAA  FRA  FTA  PHMSA  USCG

Please complete Authorization for Services on reverse side.

Hours: Monday – Friday, 7 a.m. – 5 p.m.

Effective October 1, 2000, we will no longer be able to supervise unattended children in our clinics. We ask you to notify your employees to make appropriate child care arrangements before obtaining services at one of our locations.

