



EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT
(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

Date: _____
Patient Name: _____ Date of Birth: _____
Company Name: _____ Date of Injury: _____
Address / Location#: _____

WORK-RELATED **INJURY** / **ILLNESS**

Post Accident Substance Abuse Testing:
 Drug Screen Urine Hair
 Breath Alcohol
 Urine Collection Only

TEST TYPE

DOT Regulated
 Non-Regulated

PHYSICAL EXAMINATIONS

Job Title: _____
 DOT physical
 Pre-employment / return to work
 Other: _____

DRUG TESTING

Breath Alcohol
 Hair Collection
 DOT Urine
 Non DOT Urine
 Urine Collection Only

BILLING

Bill company for services (excludes Work Comp)
 Employee to pay at time of service
 Bill Workers' Compensation Carrier
Carrier: _____
Claim#: _____
Phone #: _____
Address: _____

NOTES

EMPLOYER AUTHORIZATION

Authorized By: _____ Title: _____
Phone #: _____ Date / Time: _____

FOR DOCNOW USE ONLY

Yes Obtained consent for treatment Signature: _____
Date / Time: _____