



## Employer Authorization Form

Employee Name:

Company Name:

Authorized By:

Date:

Phone:

Injured Body Part:

Date of Injury:

Claim Number:

Bill for office visit to INSURANCE or COMPANY:

### Physicals:

- DOT
  - Pre-Employment
  - Re-Certification
- Non-DOT
  - Pre-Employment
  - Other: \_\_\_\_\_
- Asbestos Physical
- Respirator Clearance Physical
  - Respirator Fit Test
  - Respirator Clearance Certificate
  - OSHA Respirator Medical Evaluation Questionnaire
- Hazmat Physical
- Human Performance Evaluation

### Other Services:

- MMR
  - Vaccine
  - Titer
- Hepatitis A
  - Vaccine
  - Titer
- Hepatitis B
  - Vaccine
  - Titer
- TDAP
- Flu Shot
- TB Skin Test
- Audio Exam
- PFT Exam
- Vision Exam

### Drug & Alcohol Testing:

- DOT Urine Only
- DOT Breath Alcohol Only
- DOT Urine & Breath Alcohol
  - Pre-Employment
  - Random
  - Post-Accident
  - Return-to-Work
  - Reasonable Suspicion
  - Follow-Up
    - Collection Only
- Non-DOT Urine Only
- Non-DOT Breath Alcohol Only
- Non-DOT Urine & Breath Alcohol
  - Pre-Employment
  - Random
  - Post-Accident
  - Return-to-Work
  - Reasonable Suspicion
  - Follow-Up
    - Collection Only
- Rapid Drug Test
  - 5 Panel
  - 6 Panel
  - 10 Panel
- Oral Swab
- Hair Follicle Collection Only
- Employee responsible for charges