



Employers Authorization for Examination or Treatment

****** Photo ID must be presented at time of service******

Patient Name:	SSN:
Company Name:	DOB:
Address:	Date of Injury:

Physical Examination

Job Title: _____

CDL Physical **Pre-Employment** **Post Accident**
 Worker's Compensation (Insurance Carrier Information Required)

Substance Abuse Testing

<input type="checkbox"/> Non-Regulated Urine Drug Screen	<input type="checkbox"/> Nicotine Screen
Test Type	
<input type="checkbox"/> Pre-Employment	<input type="checkbox"/> Return to Duty
<input type="checkbox"/> Random	<input type="checkbox"/> Periodic
<input type="checkbox"/> Post Accident	Other: _____

Billing

<input type="checkbox"/> Bill Company	<input type="checkbox"/> Employee to pay at time of service
<input type="checkbox"/> Bill Worker's Compensation Carrier	

Authorized By: _____ **Title:** _____

Phone: _____ **Date:** _____

Please fax to: 602-548-2292 , Attention: Occ. Med Services