



AUTHORIZATION FOR EXAMINATION OR TREATMENT

Patient Name: _____ SS#: _____

Company Name: _____ Branch/Store # _____

Work Related: Date of Injury _____ Body Part _____ New Injury Follow Up

PHYSICAL EXAMINATION

- Pre-employment Annual DOT RTW Other _____
- Fit For Duty Respiratory Clearance

SUBSTANCE ABUSE TESTING

- DOT 5 Panel (send out to Lab) 5 Panel Instant Breath Alcohol Test (BAT)
- 5 Panel (send out to Lab) 10 Panel Instant Hair Collection (head only)
- 10 Panel (send out to Lab) Urine Collection only Other _____

REASON FOR SUBSTANCE ABUSE TESTING

- Pre-employment Reasonable Suspicion Post-Accident
- Random Return to Work (RTW) Follow Up

ADDITIONAL SERVICES

- Audiometry TB Skin Test PFT EKG Lift Test 50 lbs or 75 lbs
- Vision Screening Agility Test X-Ray (1 View) COVID Other _____

BILLING

- Employer Paid Insurance Carrier/TPA

Employer Name _____ HR Manager _____ Phone _____

Address _____ City/ST/Zip _____

Workers Comp Carrier Name _____ Claim # _____

Carrier Address _____ City/ST/Zip _____

AUTHORIZER'S INFORMATION (REQUIRED)

Authorized by _____ Title _____ Date _____

Phone _____ Fax _____ Email _____

Verified by _____ (PIC Staff Member)