



AUTHORIZATION FOR EXAMINATION OR TREATMENT

PATIENT NAME _____

SS# _____ - _____ - _____ **DATE OF BIRTH** _____

Work Related

Injury **Illness**

Date of Injury _____ **Type of Injury** _____

Substance Abuse Testing

- 5 Panel Drug Screen 10 Panel Drug Screen
 Collection Only Breath Alcohol
 Other _____

Type of Substance Abuse Testing

- Preplacement Reasonable Cause Post Accident
 Random Periodic Follow-up

Physical Examination

- Preplacement Baseline Annual Exit

DOT Physical Examination

- Preplacement Recertification Exit

Special Examination

- Asbestos PFT Other _____

Special Instructions/Comments: _____

Authorized by _____

Signature

Date _____

