



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 DOT Drug Screen
 Breath Alcohol Breath Alcohol DOT
 Collection Only Other _____

Type of Substance Abuse Testing

Pre-placement Reasonable Cause Post Accident
 Random Periodic Follow-up

Physical Examination

Pre-placement Baseline Annual
 Exit

DOT Physical Examination

Pre-placement Re-Certification Exit

Special Examination

Physical Capacity Profile Asbestos PFT
 Other _____

Authorized by: _____

Signature

Date: _____