OCCUPATIONAL HEALTH SERVICES
AUTHORIZATION FORM

Company: _____

Applicant/Employee Name: _____

Applicant/Employee DOB: _____

Employee Job Title:_____

Authorized by: _____

Phone number to reach person authorizing treatment: _____

SERVICES REQUESTED:

- ☐ Pre-Employment Physical (Non-DOT)(PEP)
- ☐ TB Test (TB Test)
- ☐ Chest X-Ray to Rule Out TB
- ☐ 5-panel Rapid Drug Screen (5UDS)
- ☐ 10-panel Rapid Drug Screen (10UDS)
- ☐ DOT 5-panel Drug Screen (UDSDOT)
- ☐ DOT Physical (DOTPHY)
- ☐ Non-DOT Breath Alcohol Testing (Non-DOT BAT)
- ☐ DOT Breath Alcohol Testing (DOT BAT)
- ☐ Work Comp
- ☐ Other (Specify)

_____

If drug screen is being requested, please check reason for test:

- ☐ Pre-Employment
- ☐ Random
- ☐ Reasonable Suspicion/Cause
- ☐ Post Accident
- ☐ Return to Duty
- ☐ Follow-up
- ☐ Other (Specify)

If a DOT Physical is being requested is the driver:

☐ INTERSTATE ☐ INTRASTATE

Managers Signature: _____**Date:** _____

Manager/Supervisor Phone Number :_____

Company Name: _____

Address: _____**City, State, Zip:**_____

Company Fax: _____**Email:**_____

PHOTO IDENTIFICATION REQUIRED

MINORS MUST BE ACCOMPANIED BY A PARENT OR GUARDIAN

For form or Occupational Health Services Questions Contact our Occupational Health Team:

occmed@gigogb.com Ph 517-999-CARE (2273) Prompt 6 Fax 517-482-2107