



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: