EMPLOYER'S AUTHORIZATION FOR TREATMENT

Date:_____

Patient Name:_____ Date of Birth:_____

Company Name:_____ Date of Injury:_____

Address:_____

Post Accident Substance Abuse Testing: _____ Drug Screen: [ ] 5 Panel [ ] 8 Panel [ ] 10 Panel _____ DOT Regulated Specify Agency [ ] FMCSA [ ] FAA [ ] FRA [ ] FTA [ ] PHMSA [ ] USCG _____ Non DOT Regulated _____ Urine Collection Only _____ Blood Alcohol	Physical Examinations _____ DOT Physical _____ Pre-emplyment _____ Other: _____ Drug Testing _____ Blood Alcohol _____ Urine Collection Only _____ Non DOT Urine _____ DOT Urine Specify Agency _____ [ ] 5 Panel [ ] 8 Panel [ ] 10 Panel
Billing _____ Bill company for services _____ Employee to pay at time of service _____ Bill workers' compensation carrier Carrier:_____ Claim #:_____ Phone #:_____ Address:_____ _____	Other _____ TB Test _____ Hep B Vaccine [ ] Individual [ ] Series

Employer Authorization

Authorized By:_____ Title:_____

Phone #:_____ Date / Time:_____

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