Employer's Authorization for Treatment

This form must be completed before treatment can be provided and is required for an employer related visit. Patient picture ID required.

Date _____ Patient/Employee Name _____ DOB _____

Company Name _____

Company Contact _____ Title _____

Company Address _____

City _____ State _____ Zip _____

Designated Responsible Party for Drug Screens (Name and Phone) _____

Company Phone_____ Secure Fax for Results _____ Email for Results_____

WE WILL FAX RESULTS TO A SECURE FAX LINE ONLY. If you do not have a secure fax line, please let clinical staff know.

DOT SERVICES:

☐ DOT PHYSICAL ☐ DOT DRUG SCREEN

DOT services are required to arrive 3 hours before close of business.

Please Specify DOT Agency:

☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG

Other Testing Authorities:

☐ HHS Drug Screen ☐ NRC Drug Screen

Reason for Testing:

☐ Pre-Employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return/Duty ☐ Follow Up

☐ Other _____

If ONLY DOT services are needed - STOP HERE.

OTHER OCCUPATIONAL SERVICES:

☐ General Physical Exam

☐ Other Physical (Special Instructions) _____

☐ Audiogram ☐ Hepatitis B Titer (Lab) ☐ Hepatitis B Shot Series

☐ Chest X-Ray ☐ PPD (TB Test) ☐ CXR B Read ☐ Blood Lead Level (Lab)

☐ PFT/Spirometry (w/Letter) ☐ Tetanus Shot ☐ Flu Shot ☐ ZPP(Lab)

☐ Vision ☐ Peripheral Vision ☐ Ishihara Color Vision ☐ Lift Test

DRUG SCREENS: *AppleCare utilizes LabCorp of America for all drug screen and lab use, unless employee presents with a pre-printed COC directing otherwise from an employer. AppleCare provides MRO Services, contact our Occ Health Dept for information.*

INSTANT

☐ 5 Panel **Instant**

☐ 10 Panel **Instant**

SEND OUT

☐ 5 Panel NON-DOT Send Out

☐ 10 Panel NON-DOT Send Out

☐ Collection only (AppleCare is not MRO)

☐ Hair Sample

☐ Breath Alcohol

☐ DOT ☐ NON-DOT

DER_____

All NON-Negative results on instant drug screens will require send out confirmation.

AUTHORIZED BY: We (Employer) are authorizing AppleCare to provide treatment to said employee. By doing so, we acknowledge that we are responsible for payment of any/all services in the event a claim is not filed and paid in our behalf.

Name_____ Signature_____