



Employer Authorization Form

Employee Name: _____ DOB: _____ Last 4 SS#: _____

Employee Address: _____ City: _____ State: _____ Zip: _____

Employee Phone #: _____ Scheduled Date(s): _____ Time: _____

Company Name: _____

Company Address: _____ City: _____ State: _____ Zip: _____

Treatment Authorized by: _____
Name and Title (please print)

Signature: _____ Phone: _____

Employer Information

DER/Company contact for results and/or physician call: _____

Preferred communication (please check all that apply) ☐ phone ☐ fax (secure) ☐ e-mail ☐ mail

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____

Phone: _____ Ext. _____ Secure Fax: _____

Billing Address (only if different than above):

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Ext. _____ Fax: _____

If billing to carrier – Policy #: _____ Effective Dates of Policy: _____ to _____

Company or WC Insurance Carrier: _____

Claim #: _____

Adjuster Name: _____

Adjuster Phone: _____

☐ Injury/Accident Date of Injury: _____ Injured Body Part: _____

Employer Authorization Form

For OccMed services ONLY, please use the following Athena package name and ID.

Package Name: _____

ID: _____

Please provide the employee with the following services: (Please check all that apply)
Drug and/or Alcohol Testing (Please check type and reason below)

PLEASE SELECT EITHER OPTION 1 OR OPTION 2

OPTION 1: Using MedExpress lab and MRO

- ☐ Breath Alcohol Test - Please check: ☐ DOT or ☐ Non-DOT
- ☐ DOT Urine Drug Screen (5-panel)
Please check one: ☐ FMCSA ☐ FAA ☐ FRA
☐ FTA ☐ PHMSA ☐ USCG
- ☐ Rapid Urine Drug Screen (Non-DOT)
☐ 5-panel
☐ 10-panel
- ☐ 5-Panel Standard Urine Drug Screen (Non-DOT)
☐ 10-Panel Standard Urine Drug Screen (Non-DOT)
☐ Custom Panel #: _____
- ☐ Hair Drug Screen - Please check: ☐ 5-panel or
☐ 5-panel w/exp. opiates
- ☐ Blood Alcohol Testing*
- ☐ Oral Fluid Cotinine Test (PA ONLY)

OR

Collection Only

Urine Drug Screen:

- ☐ DOT
☐ Non-DOT

Hair Drug Screen:

- ☐ Hair Drug Screen

Rapid Urine Drug Screen (Non-DOT):

- ☐ 5-panel
☐ 10-panel

Breath Alcohol Test:

- ☐ DOT
☐ Non-DOT

CCF:

- ☐ On file at center
☐ Donor will arrive with

Reason for Drug/Alcohol Testing:

- ☐ Pre-Placement ☐ Post-Accident ☐ Reasonable Suspicion
☐ Random ☐ Return-to-Duty
☐ Follow-Up ☐ Observed Collection

PHOTO ID IS REQUIRED!

Physical Examination:

- ☐ DOT - Please check: ☐ New Certification
☐ Re-Cert
☐ Follow-up
- ☐ Pre-Placement Basic (Non-DOT)
☐ Respirator Questionnaire Clearance
☐ Return-to-Work Evaluation
☐ Special company protocol/form:

☐ Other:

Other Services:

- ☐ TB skin test/PPD - 1 step
☐ TB skin test/PPD - 2 step
☐ Hepatitis A vaccine
☐ Hepatitis B vaccine
☐ Flu shot
☐ EKG
☐ Other: _____

Additional Services*:

- ☐ Quantitative Resp. Fit Test
☐ OSHA Pulmonary Function Test
☐ Lift Testing

Labs:

- ☐ Lead level
☐ Hep B titer (HepBsAB)
☐ MMR titer
☐ CBC
- ☐ Qualitative Resp. Fit Test
☐ Spirometry Test
☐ Audiogram OSHA Threshold

*Please call the the Outcomes Assurance team (304-985-6324) to verify availability of test.