



OccMed
PHYSICIANS



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AUTHORIZATION FOR SERVICES

Check all services requested. | **Incomplete forms may delay testing.**

1 EMPLOYEE INFORMATION

Employee Name: _____ Date of Birth: ____ / ____ / ____ Phone: _____

2 COMPANY INFORMATION

Company Name: _____ Phone: _____

Today's Date: ____ / ____ / ____

Expiration Date: ____ / ____ / ____

3 SERVICES REQUESTED

Check all that apply.



DRUG & ALCOHOL TESTING

- ☐ DOT Drug Screen
- ☐ Non-DOT Drug Screen
- ☐ Instant Drug Screen
- ☐ Breath Alcohol Test

REASON (Choose one):

- ☐ Pre-Employment
- ☐ Random
- ☐ Post-Accident
- ☐ Reasonable Suspicion
- ☐ Return-to-Duty
- ☐ Other: _____



PHYSICAL EXAMS

- ☐ Pre-Employment Physical
- ☐ Return-to-Work / Fitness for Duty
- ☐ DOT Certification
- ☐ Respirator Medical Evaluation
- ☐ Other: _____



TB TESTING

- ☐ PPD Skin Test
- ☐ Quantiferon Gold Blood Test
- ☐ Other: _____



OTHER SERVICES

- ☐ Respirator Fit Test
- ☐ Hearing Test (Audiogram)
- ☐ Vaccine(s)
- ☐ Other: _____

4 INJURY TREATMENT (If Applicable)

☐ **Injury Treatment Needed**

If checked, please complete the information below.

Date of Injury: ____ / ____ / ____

Time of Injury: _____ AM / PM

Body Part Injured: _____