

Authorization for Services

Date: _____

Employee Name: _____

Company Name: _____

Date of Birth: _____

Company Contact: _____

Employee Phone #: _____

Company Phone #: _____

Reason for Visit:

☐ Pre-Placement ☐ Random ☐ Periodic ☐ Return to Duty
☐ Post Accident ☐ Reasonable Suspicion ☐ Observation Required

Substance Abuse Testing

Testing Type

☐ WorkFit House	☐ Collect Only
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DOT Testing

☐ Urine Drug	☐ Breath Alcohol
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Non-DOT Testing

☐ Breath Alcohol

Rapid

☐ 5 Panel THC	☐ 5 Panel No THC
☐ 10 Panel THC	☐ 6 Panel No THC
☐ 13 Panel THC	☐ 9 Panel No THC
☐	☐ 11 Panel No THC
☐	☐ 12 Panel No THC

Lab

☐ 5 Panel THC	☐ 5 Panel No THC
☐ 10 Panel THC	☐ 7 Panel No THC
☐	☐ 10 Panel No THC

Hair

☐ 5 Panel THC	☐ 4 Panel No THC
☐ Exp. Opiates	☐

Physical Exam

☐ 19A	☐ DOT/CDL
☐ Non-DOT (Basic)	☐ Return to Work
☐ School/Sport	☐ Fit for Duty
☐ Firefighter Int.	☐ Firefighter Ext.
☐ OSHA Asbestos	☐ OSHA Hazmat
☐ OSHA Respirator	☐ OSHA Silica

☐ Workers Comp.	☐	☐
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Vaccines/Lab Testing

☐ Hepatitis B Vacc	☐ Hepatitis B Titer
☐ MMR Vaccine	☐ MMR Titer
☐ Varicella Vaccine	☐ Varicella Titer
☐ Tetanus TD Vacc	☐ Measles Titer
☐ Tdap Vaccine	☐ Rubella Titer
☐ Flu Vaccine	☐ Rubella Titer
☐ QuantiFERON	☐ PPD
☐ Lead	☐ ZPP
☐ Other _____	

Additional Services

☐ Chest XR Standard	☐ Chest XR B-Read
☐ Pulmonary Function Test	☐ EKG
☐ HPE	☐ Audiogram
☐ Full Vision	☐ Vision _____
☐ Qualitative Mask Fit	☐ Quantitative Mask Fit
☐ Respirator Questionnaire Review Only	☐ Rapid Antigen COVID Test

Billing Information:

☐ Bill Company ☐ Bill TPA ☐ Bill Employee ☐ Bill Workers Comp

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Hours of Operation: Monday, Tuesday,

Wednesday, Friday: 7AM-5PM

Thursday: 7AM-7PM, Weekends: 9AM-2:30PM

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