The Clinic at Elm Lake, PA

EMPLOYER AUTHORIZATION

PH 662-240-9999 FAX 662-241-5451

Company: _____ **Date:** _____

Employee: _____ **PHOTO ID REQUIRED**

Select One: ___ Bill Company ___ Bill Work Comp Ins ___ Employee to Pay

Work Related Injury

Date of Injury: _____
Work Comp Ins: _____
WC Claim Number: _____
Injury: _____

___ EVALUATE & TREAT ___EVALUATE ONLY
___ Immunizations: □ Tetanus □ Hep B □ Update if needed
Please select Substance Abuse Testing if needed.

DOT

___ DOT Physical Examination
___ DOT Urine Drug Screen
(Use Clinic's Chain of Custody form)
Sent to outside lab - Usually result 24 - 48 hrs
___ DOT Urine Drug Screen COLLECT ONLY
MUST bring kit & COC form
___ DOT Breath Alcohol

Examinations & Procedures

□ Pre-Employment □ Annual □ Other: _____

___ Physical Examination:
□ DOT
□ Basic:
Basic exam, short medical history, vital signs, distant vision, basic color vision, conversational hearing
□ Comprehensive:
In depth exam, long medical history, vital signs, distant/near vision test, Titmus vision test
___ Audiogram/Hearing Test
___ Vision:
□ Titmus (Depth perception/color & acuity near/far)
□ Snellen (Near/Far)
___ EKG
___ Spirometry/PFT (Measures lung capacity)
___ Respirator Fit
___ Respirator Questionnaire
___ X-ray (Specify): _____
___ Labs: □ CBC □ Other_____
___ Immunizations: □ Tetanus □ Hep B □ Update if needed
□ Other: _____

Special Requests

___ Hand Evaluation
___ Fit for Duty (Medical Records Required Before Appt)
___ Travel Consultation for Travel to _____
___ OTHER: _____

Substance Abuse Testing

□ Pre-Employment □ Random □ Reasonable Cause
□ Periodic □ Post Accident □ Follow Up

Urine Drug Screen:
□ Call Employee Representative, if non-negative.
□ Send for confirmation, if non-negative.

___ DOT (Use Clinic's Chain of Custody form)
Sent to outside lab - Usually result 24 - 48 hrs
___ DOT COLLECT ONLY
MUST bring kit & COC form

___ NON DOT Instant:
□ 5-2 Panel: AMP/COC/MET/OPI/THC
□ 5-3 Panel: AMP/COC/OPI/PCP/THC
□ 10 Panel: BZO/BAR/MET/OPI/PCP/AMP/COC/MDMA/MTD/THC
___ NON DOT COLLECT ONLY
MUST bring kit & COC form

Other:
___ Breath Alcohol
□ DOT
□ NON DOT
___ Saliva
___ Hair Collection – MUST bring kit & COC form

___ Other _____

Special Instructions

_____
_____
_____

By signing this, I agree to pay all requested services in full, whether approved or not by the insurance carrier.

Company Representative Signature: _____ **Date:** _____

Print Name: _____ **Phone:** _____