Employer Authorization Form

Complete this form and present at the time of service.

Date: _____ Patient Name: _____

Company: _____ Phone: _____ Fax: _____

Company Address: _____

Primary Contact: _____ BT Account #: _____

REQUIRED SERVICES (check all that apply)

Work Related

☐ Worker's Compensation Injury Treatment:

Date of Injury: _____

Type of Injury: _____

_____

_____

☐ Post-accident Drug Screen required

Drug Screen/Breath Alcohol Testing

☐ Drug Screen

☐ DOT: (check agency below)

DOT Agency: ☐ FMCSA ☐ FTA ☐ PHMSA ☐ FAA ☐ FRA ☐ USCG

☐ Non-DOT: (fill in test code below)

☐ 5 Panel ☐ 9 Panel ☐ 10 Panel ☐ 7 Panel ☐ Other _____

☐ Instant

☐ Breath Alcohol

☐ DOT ☐ Non-DOT

Physical Examination

☐ DOT Physical

☐ Pre-Employment PE

☐ Respiratory Clearance PE

☐ Physical (Other):

Specify: _____

Special Examination

☐ Audiogram ☐ Blood Lead Level

☐ Chest X-ray ☐ Hepatitis B Immunization

☐ Hepatitis B Profile ☐ Spirometry with Letter

☐ PPD (TB test) ☐ Tetanus

☐ Flu Shot

☐ Other: _____

☐ Other: _____

REQUIRED FOR ALL WORKER'S COMPENSATION CLAIMS:

Has Employer filled out First Report of Injury? ☐ Yes ☐ No (send copy if available)

Where are claims to be filed? ☐ Employer ☐ Carrier ☐ Billing Company

W/C Carrier: _____ Phone: _____ Policy #: _____

Address: _____

BILLING COMPANY INFORMATION (OPTIONAL):

Billing Company: _____ Phone: _____ Policy #: _____

Address: _____

This Certifies that the above information is correct.
I authorize the medical provider to provide medical treatment to the employee named above.

_____ _____

Signature or Company Authorization Number Date

_____ _____

Printed Name Position Title

For Internal Use Only

_____ _____

Form Completed By Initials

_____ _____

Center Name Date

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