# PATIENT

## Occupational Medicine

Medical Authorization *(Lite)*

Employee Name: ______________________ Date: ______________________

Company /Job Site: ______________________ Contact Name: ______________________

Social Security #: ______________________ Job Number: ______________________

☐ Injury Treatment: ☐ Bill Company ☐ Bill Insurance Carrier (Work Comp Policy)

Insurance Carrier Information: **It is the responsibility of the company to call in a First Report of Injury (Form IA-1) to your workers compensation insurance carrier.*

Name: ______________________ Phone: ______________________ Claim #: ______________

Address: ______________________ Adjuster: ______________________

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☐ Physical Exam
- Type: ☐ DOT ☐ Non-DOT w/ UA ☐ Return-to-Work Exam
- Reason: ☐ Pre-Employment ☐ Annual ☐ Re-Certification ☐Other:

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☐ Breath Alcohol
- Type: ☐ DOT ☐ Non-DOT
- Reason: ☐ Pre-Employment ☐ Random ☐ Post-Accident ☐ Return-to-Work ☐ Reasonable Suspicion

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☐ Urine Drug Screen
- Type:
  - ☐ Quick Screen: ☐ 5 Panel ☐ 10 Panel ☐ 12 Panel
  - ☐ Non-DOT: ☐ 5 Panel ☐ 10 Panel ☐ 12 Panel
  - ☐ DOT: ☐ FMCSA ☐ PHMSA ☐ USCG ☐ FTA
  - ☐ Custom Panel: ☐ Synthetic Marijuana ☐ Synthetic Opioid
- Reason: ☐ Pre-Employment ☐ Random ☐ Post-Accident ☐ Return-to-Work ☐ Reasonable Suspicion
- Observed: ☐ Yes ☐ No

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☐ DISA
- Type:
  - ☐ BAT (Non-DOT)
  - ☐ BAT (DOT)
  - ☐ Urine (Non-DOT)
  - ☐ Urine DOT: ☐ PHMSA ☐ USCG ☐ FMCSA
- Reason: ☐ Pre-Employment ☐ Random ☐ Post-Accident ☐ Return-to-Work

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☐ Vision Testing
- ☐ Snellen
- ☐ Peripheral Only

☐ X-Ray
- ☐ X-Ray Type: ______________

☐ COVID-19 Test
- ☐ PCR
- ☐ Rapid Antigen

☐ Accucheck

☐ EKG

☐ TB Skin Test

☐ Laboratory Tests: ______________________________________________

☐ Other: ______________________________________________

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______________________________ Authorized Signature

(________)__________-______________ Phone Number