Work Health Solutions

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www.workhs.com

Authorization for Treatment Form

Employee Name: _____ **Date:** _____

Company: _____ **Contact Name:** _____

Phone Number: _____ **Send Bill to:** ☐ **Employer as listed above** ☐ **Work Comp Insurance**

☐ **Injury Treatment:** _____

☐ **Physical Exam:** ☐ DOT ☐ Non-DOT ☐ HAZMAT ☐ Asbestos ☐ Operator
☐ Pre-Placement ☐ Annual ☐ Semi-Annual ☐ Re-Certification ☐ Other _____

☐ **Breath Alcohol:** ☐ DOT ☐ Non-DOT

☐ **Drug Screen:** ☐ Rapid Urine ☐ Non-DOT (Urine) ☐ K-2 Testing ☐ DOT (Urine) ☐ Collection Only
☐ 5 Panel ☐ Pre-Placement ☐ Reasonable Suspicion DOT Agency ☐ DOT
☐ 10 Panel ☐ Random ☐ Return To Duty _____ ☐ Non-DOT
☐ 2 Panel ☐ Post-Accident ☐ Follow-Up
☐ Other: _____

☐ **Hair Test:** ☐ WHS Hair Test ☐ Hair Collection Only

☐ **DISA:** ☐ Pre-Placement ☐ Urine (Non-DOT) ☐ DOT Agency
☐ Random ☐ Urine (DOT) _____
☐ Post-Accident ☐ BAT (Non-DOT)
☐ Hair ☐ BAT (DOT)

☐ **Respirator Fit Test:** ☐ ☐ Quantitative ☐ Full Face ☐ Half Face Brand/Series: _____

☐ **Pulmonary Function Test**
☐ **Audiogram**
☐ **Return to Work Clearance**
☐ **Safety Evaluation**
☐ **TB Skin Test** (Employee must be able to return to the clinic within 2 days to have test read)
☐ **Laboratory Tests:** _____
☐ **Other:**

☐ **Medical Record Evaluation**
☐ **Titmus Vision Testing**
☐ **Fit for Duty Clearance**
☐ **Emerge Baseline**

_____ ( ) -

Authorized Signature **Phone Number**