Work Health Solutions

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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
☐ 5 Panel
☐ 10 Panel
☐ K-2 Test

Reason for Test
☐ Pre-Placement
☐ Random
☐ Post-Accident
☐ Other: _____

☐ Reasonable Suspicion
☐ Return To Duty
☐ Follow-Up

☐ DOT (Urine)
DOT Agency
_____

☐ Collection Only
☐ DOT
☐ Non-DOT

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

☐ **DISA:** ☐ Pre-Placement ☐ Random ☐ Post-Accident ☐ Hair

☐ Urine (Non-DOT)
☐ Urine (DOT)
☐ BAT (Non-DOT)
☐ BAT (DOT)

☐ DOT Agency
_____

☐ **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**

*Payment for a possible work-related issue remains the financial responsibility of the authorizing company until denial of the claim is confirmed in writing.

_____ ( ) -

Authorized Signature **Phone Number**