

Employer's Authorization Form

Must be completed in <u>Full</u> prior to the arrival of your employees. Check all that applies.



VALID PHOTO ID REQUIRED FOR ALL VISITS

Employee:	Date of Birth//	
Last,	First, Middle Initial	
DRUG SCREEN	□ WORK RELATED INJURY	
□ DOT	Location of injury on body	
□ Non- DOT	Date of injury	
☐ Urine ☐ Hair	WORKER COMPENSATION INSURANCE DETAILS:	
□ 6-panel□ 10-panel	Name of insurance carrier:	
Social security number is required for all urine drug screens and B.A.T. SSN:	Billing address for carrier:	
	Address cont.:	
REASON FOR DRUG SCREEN Pre-Employment Post Accident Random	Claim number or Full Social	
	Failure to provide a claim number or full social security number can result in delay or denial of services.	
☐ Reasonable Cause☐ Follow-Up☐ Other	EMPLOYER: □ Please bill Employer for all services	
	Business Name:	
PHYSICAL EXAM ☐ Pre-Employment ☐ DOT Initial ☐ DOT Recertification	Business Address:	
	Business Phone Number:	
OTHER SERVICES ☐ Audiogram ☐ Chest X-ray ☐ EKG ☐ Hepatitis B Vaccine	Business fax/email:	
	Human resources contact name:	
	We agree to be financially responsible for any medical treatment/services provided to the employee named above.	
☐ TB Skin Test☐ Tetanus Vaccine	Authorized Signature:	
 ☐ Pulmonary Function Test ☐ Breath Alcohol Test (B.A.T) 	Print Name:	
	Position:	
	Date:	

Ann Arbor	Brighton	Hartland	South Lyon
1785 W. STADIUM BLVD	8685 W GD RIVER AVE	11554 HIGHLAND RD	22316 PONTIAC TRAIL
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