Employer's authorization for treatment and/or examination
(Must Present Photo ID at Time of Service)

Patient Name:_____ SS/DOB#:_____

Job Title:_____ Company:_____

Company Address:_____

Comp Phone #:_____Company Contact:_____

W/C Carrier if Applicable_____

Employer Signature:_____ Date:_____

Work Related/ Injury Care:
Date of Injury_____

__ Evaluate and Treat

__ **LIGHT DUTY IS AVAILABLE**

Return to Work Evaluation:

__Physical __Functional Job Testing

__ FIT FOR DUTY

Special Instructions/Other Tests
_____
_____
_____
_____

- **Employee to pay charges**

Physical Evaluation:
__Pre-Employment __Non DOT __DOT __Exit

Substance Abuse Testing:

__Urine Drug Collection __ Breath Alcohol Testing

__ Observed Urine Drug Collection __ Hair Analysis

__ Post Accident __ Random __Preplacement __ Other

Physical Performance Evaluation:

__Respirator Fit Testing (Items may require
__Qualitative Basic Physical)

__Quantitative: Mask Type*_____

__Pulmonary Function Test (PFT)
*Required

__ Audiogram __ Labs_____

_____