MEDICAL AUTHORIZATION

Date: _____ **Patient Name:** _____

Company: _____ **Phone:** _____**Fax:** _____

Company Contact: _____ **Phone:** _____

Address:_ _____**City:** _____**Zip:** _____

Authorization: _____
Signature **Printed Name**

Verbal Authorization given by: _____

Verbal Authorization taken by: _____

Photo ID Required

Drug Screen	**Post Accident** ☐ **Random** ☐ **Replacement** ☐ **Suspicion/Cause** ☐	☐ **DOT**	☐ **Non-DOT** ☐ **E-Cup Instant** ☐ **Lab based (greater than 5 panel)**
Breath Alcohol	**Post Accident** ☐ **Random** ☐ **Replacement** ☐ **Suspicion/Cause** ☐	☐ **DOT**	☐ **Non-DOT**
Physical Exam	☐ **Physical Exam** ☐ **DOT Exam** ☐ **Return to work**		
Immunizations	☐ **Hepatitis A** ☐ **Hepatitis B** ☐ **PPD**		

Patients under 18 years of age need written or verbal parental consent for physicals, injury treatment, and/or injections.