MED-1 OCCUPATIONAL HEALTH SERVICES
AUTHORIZATION FORM

Company Name: _____ **Staffing Agency:** _____

Patient Name: _____ **Date:** _____ **(**valid for 48 hour

Authorized By: _____ **Time In:** _____ **AM PM**

Phone # : _____ **Email :** _____

****PHOTO ID REQUIRED****

INJURY

INJURY

Treatment/Evaluation

☐ Treatment of alleged work-related injury or illness Date of Injury: _____ Time of Injury: _____AM/PM

What is the type of injury or illness? _____

☐ Drug Screen with initial visit ☐ Breath Alcohol Test with initial visit

NON - INJURY

	NON - DOT PROCEDURES	*DOT PROCEDURES*
PHYSICAL EXAMS	***Physical Examination*** ☐ Post Offer/Pre-employment ☐ Return to Work ☐ Fit for Duty ☐ Respiratory ☐ Hazmat ☐ Asbestos ☐ Other	***Physical Examination*** ☐ New ☐ Recertification ☐ Follow-up
DRUG TESTS	***Drug Test - Type*** ☐ Urine (circle panel type) 2 3 4 5 7 9 10 12 Expanded Opiates Nicotine ☐ Rapid (circle panel type) 3 5 7 10 Nicotine ☐ Collection Only ☐ Hair ☐ Saliva (circle panel type) 5 7 10 ***Reason for Drug Test*** ☐ Pre-Employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Work ☐ Follow-Up Testing ☐ Other ☐ Observed	***Drug Test - Federally Mandated*** ☐ Urine ☐ Collection Only ***Reason for Drug Test*** ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty (Observed) ☐ Follow-Up (Observed) ☐ Other ☐ Observed
ALCOHOL TESTS	***Breath Alcohol Test - Type*** ☐ Breath ***Reason for Alcohol Test*** ☐ Pre-Employment ☐ Random ☐ Post Accident ☐ Reasonable Suspicion/Cause ☐ Return to Work ☐ Follow-Up	***Alcohol Test - Federally Mandated*** ☐ Breath Alcohol Test ***Reason for Alcohol Test*** ☐ Pre-Employment ☐ Random ☐ Post Accident ☐ Reasonable Suspicion/Cause ☐ Return to Work/Return to Duty ☐ Follow-Up
OTHER	☐ Hepatitis B Vaccine #_____ ☐ Chest X-Ray ☐ Pulmonary Function Test ☐ Labs _____	☐ TB Skin Test Single _____ 2 Step _____ ☐ TB Blood Test ☐ Audio Test ☐ Vision Test ☐ Lift Test #_____
COMPANY INSTRUCTIONS	**Other testing and/or company specific instructions:**	
MED-1 INSTRUCTIONS	Please arrive 30 minutes prior to clinic closing time. PHYSICAL EXAM: Please bring your glasses or contacts DRUG SCREENING: Do not urinate prior to arrival PULMONARY FUNCTION TEST: Do not eat, use an inhaler, or smoke one hour prior to arrival	

- **Employer accepts financial responsibility for authorized visits**

Additional authorization forms available at med1occupationalhealth.com **Reviewed 11-2020**