



# MED-1 OCCUPATIONAL HEALTH SERVICES AUTHORIZATION FORM

Company Name: \_\_\_\_\_ Staffing Agency: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ (valid for 48 hours)  
 Authorized By: \_\_\_\_\_ Time In: \_\_\_\_\_ AM PM  
 Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

**\*\*PHOTO ID REQUIRED\*\***

## 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
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**PHYSICAL EXAMS**  
**Physical Examination**  
 Post Offer/Pre-employment  Respiratory  
 Return to Work  Hazmat  
 Fit for Duty  Asbestos  
 Other

**PHYSICAL EXAMS**  
**Physical Examination**  
 New  
 Recertification  
 Follow-up

**DRUG TESTS**  
**Drug Test - Type**  
 Urine (circle panel type)  
                   4 5 7 9 10 12 Expanded Opiates Nicotine  
 Rapid (circle panel type)  
                   3 4 5 7 9 10 Nicotine  
 Collection Only  
 Hair  
 Saliva (circle panel type)  
                   5 7 10  
**Reason for Drug Test**  
 Pre-Employment  Return to Work  
 Random  Follow-Up Testing  
 Reasonable Suspicion/Cause  Other  
 Post Accident  Observed

**DRUG TESTS**  
**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  Return to Work  
 Random  Follow-Up  
 Post Accident  
 Reasonable Suspicion/Cause

**ALCOHOL TESTS**  
**Alcohol Test - Federally Mandated**  
 Breath Alcohol Test  
**Reason for Alcohol Test**  
 Pre-Employment  Return to Work/Return to Duty  
 Random  Follow-Up  
 Post Accident  
 Reasonable Suspicion/Cause

**OTHER**  
 Hepatitis B Vaccine # \_\_\_\_\_  
 Chest X-Ray  
 Pulmonary Function Test  
 Labs \_\_\_\_\_

**OTHER**  
 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