Print Form

Employer Authorization Form

Complete this form and present at the time of service.

Date: _____ Patient Name: _____

Company: _____ Phone: _____ Fax: _____

Company Address: _____

Primary Contact: _____ BT Account #: _____

REQUIRED SERVICES (check all that apply)

Work Related

- ☐ Worker's Compensation Injury Treatment:
  - Date of Injury: _____
  - Type of Injury: _____
- ☐ Post-accident Drug Screen required

Drug Screen/Breath Alcohol Testing

- ☐ Drug Screen
  - ☐ DOT: (check agency below)
    - DOT Agency: ☐ FMCSA ☐ FTA ☐ PHMSA ☐ FAA ☐ FRA ☐ USCG
  - ☐ Non-DOT: (fill in test code below)
    - ☐ 5 Panel ☐ 9 Panel ☐ 10 Panel ☐ 7 Panel ☐ Other _____
  - ☐ Instant
- ☐ Breath Alcohol
  - ☐ DOT ☐ Non-DOT

Physical Examination

- ☐ DOT Physical
- ☐ Pre-Employment PE
- ☐ Respiratory Clearance PE
- ☐ Physical (Other):
  - Specify: _____

Special Examination

- ☐ Audiogram
- ☐ Blood Lead Level
- ☐ Chest X-ray
- ☐ Hepatitis B Immunization
- ☐ Hepatitis B Profile
- ☐ Spirometry with Letter
- ☐ PPD (TB test)
- ☐ Tetanus
- ☐ Flu Shot
- ☐ Other: _____
- ☐ Other: _____

REQUIRED FOR ALL WORKER'S COMPENSATION CLAIMS:

Has Employer filled out First Report of Injury? ☐ Yes ☐ No (send copy if available)

Where are claims to be filed? ☐ Employer ☐ Carrier ☐ Billing Company

W/C Carrier: _____ Phone: _____ Policy #: _____

Address: _____

BILLING COMPANY INFORMATION (OPTIONAL):

Billing Company: _____ Phone: _____ Policy #: _____

Address: _____

This Certifies that the above information is correct.
I authorize the medical provider to provide medical treatment to the employee named above.

Signature or Company Authorization Number _____ Date _____

Printed Name _____ Position Title _____

For Internal Use Only

Form Completed By _____ Initials _____

Center Name _____ Date _____