



[Occupational Medicine](#) • [Walk-In Emergency Center](#) • [Family Medicine](#)

SERVICE AUTHORIZATION

Company Information:

Company Name: _____

Contact: _____ Phone #: _____

Donor Information

Donor Name: _____

Social Security #: _____ - _____ - _____ Date Birth: ____/____/____

Reason for Visit:

- | | |
|--|--|
| <input type="checkbox"/> Pre-Employment | <input type="checkbox"/> Random |
| <input type="checkbox"/> Suspicion/Cause | <input type="checkbox"/> Post Accident |
| <input type="checkbox"/> Return to Duty | <input type="checkbox"/> Follow-up |
| <input type="checkbox"/> Other (specify) _____ | |

Service Requested:

Physical Exam:
 DOT 19A Non-DOT / Pre-employment / Yearly

Urine drug screen collection:
 DOT Non-Dot

Other:
 EBT Breathalyzer Hair Collection
 Other: _____

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