First Care Medical Centers, P.A.

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EMPLOYER AUTHORIZATION FORM

Patient Name:_____ **Date:**_____

Company: _____ **Location:**_____

Treatment Authorized by:_____
Name and Title (Please Print)

Signature: _____ **Phone:**_____

☐ **Injury/Accident** **Date of Injury:**_____ **Injured Body part:**_____

WC Insurance Carrier:_____ **Claim#:**_____

Please provide the above patient with the following services: (please check all that apply)
Drug and / or Alcohol Testing (Please check type and reason below)

PLEASE SELECT EITHER OPTION 1 OR OPTION 2

OPTION 1: Using First Care Medical's Lab and MRO

☐ Breath Alcohol Test: ☐ DOT or ☐ Non- DOT
☐ DOT Urine Drug Screen (5-panel)
Please check one: ☐FMCSA ☐FAA ☐FRA ☐FTA ☐PHMSA ☐USCG
☐ Rapid Urine Drug Screen – 6 panel (Non-DOT)
☐ 5-Panel Standard Urine Drug Screen(Non-DOT)
☐ 8-Panel Standard Urine Drug Screen(Non-DOT)
☐ 10Panel Standard Urine Drug Screen(Non-DOT)
☐ Custom Panel#788868 w/ Exp Opiates
☐ Hair Drug Screen – 5 Panel

OR

OPTION 2: Using your company paperwork, lab, MRO

COLLECTION ONLY
Urine Drug Screen:
☐ DOT
☐ Non-DOT

CCF:
☐ On file at Center
☐ Donor will bring

Hair Drug Screen:
☐ Hair Drug Screen – 5 Panel

Rapid Urine Drug Screen (Non-DOT)
☐ Collection per COC Provided

Reason for Drug/Alcohol Testing:
☐Pre-employment ☐Post-Accident ☐Random
☐Reasonable suspicion ☐Return to Duty ☐Follow-Up
☐Observed Collection

PHOTO ID IS REQUIRED

Physical Examination:
☐ DOT - ☐New Certification ☐Re-cert ☐Follow-Up
☐ Pre-employment Basic (Non-DOT)
☐ Respirator Certification & Questionnaire
☐ Special company protocol/form
☐ OSHA Pulmonary Function Test
☐ Audiogram OSHA Threshold
☐ Lift Testing
☐ Other _____

Other Services:
☐TB skin test/PPD
☐Hepatitis A vaccine
☐Hepatitis B vaccine
☐MMR Vaccine
☐Flu Shot
☐EKG
☐Xray - _____
☐Other _____

Lab Services:
☐Lead Level
☐Hep B titer
☐Hep C titer
☐MMR titer
☐CMP
☐CBC
☐Other _____

DER/Company Contact for results:_____
Preferred communication (please check all that apply): ☐phone ☐fax (secure) ☐email ☐mail
Address:_____City:_____
State: _____Zip Code:_____Email:_____
Phone :_____ext:_____ Secure fax:_____
Billing Address (if different from above): _____City:_____
State: _____Zip code: _____Phone: _____Fax:_____