60 Exchange Street, Suite B-7
Richmond Hill, GA 31324
(912) 756-2273
Fax (912) 756-3773

EXPERCARE
Occupational Medicine

318 Mall Blvd, Suite 300B
Savannah, GA 31406
(912) 358-1515
Fax (912) 480-0505

AUTHORIZATION FORM

Company Name/Tax ID:	**Employee Name:**
Company Contact:	**Date of Service:**
Contact Phone #:	**Reason for service:**

PLEASE SELECT ALL SERVICES THAT YOU WOULD LIKE PERFORMED:

EXAM

- ☐ Occupational (Non-DOT) Physical
- ☐ DOT Physical
- ☐ Return to Duty Exam

WORK RELATED INJURY

Date of Injury: _____

Claim #: _____

- ☐ Initial Evaluation & Treat
- ☐ Revaluation

I understand I am requesting treatment for the above mentioned individual for a work-related incident. If I do not provide a claim number within 7 days of the treatment date, I understand that all costs will be the responsibility of the company to pay.

Signature:_____

DRUG SCREENING

NON-DOT DRUG SCREENS

- ☐ Instant 5-Panel *
- ☐ Instant 12-Panel *
- ☐ Collection Only *(Use company COC)*

DOT DRUG SCREENS

- ☐ DOT Drug Screen *(Use Expercare COC)*
- ☐ Collection Only *(Use company COC)*

SCREENINGS

- ☐ Vision Screen
- ☐ Audiometry
- ☐ EKG

HAIR TESTING

- ☐ Hair Collection & Screen *(Use Expercare COC)*
- ☐ Hair Collection Only *(Use company COC)*

MISCELLANEOUS SERVICES

- ☐ TB Test (PPD)
- ☐ Hep B Vaccine ☐ Titers
- ☐ (Spirometry)

Respirator Fit Test (Qualitative)

ALCOHOL TESTING

- ☐ Breath Alcohol Testing
- ☐ Blood Alcohol Testing
  - ☐ DOT ☐ NON-DOT

**Please note that ALL non-negative instant drug screens will be sent out for confirmation at employer's expense.*

OTHER: _____

Special Notes and instructions:

_____

_____

This form will serve as your authorization to perform the selected procedures and tests on your employee. Please sign and date below. Please contact us if you have additional requests not shown on this list or if you have further questions or instructions. It is our pleasure to serve your occupational medicine needs.

_____ _____ _____

(Signature of Company Representative) *(Printed name)* *(Date)*