



Employer Authorization for Treatment

This form must be completed before treatment can be provided and is required for an employer related visit.

PATIENT PICTURE ID REQUIRED

COMPANY/EMPLOYEE INFORMATION			
Date	Employee Name	DOB	
Company Name			
Company Address			
		City	State
		Zip	
Designated Responsible Party for Drug Screens/BAT		Name	Phone
Company Phone		Secure Fax	Email Results
*We are only able to fax to a SECURE line. If you do not have a secure fax please let clinical staff know.			
DOT SERVICES			
*DOT Drug Screen Required to Arrive 3 Hours Before Close of Business			
<input type="checkbox"/> DOT Physical (DOTPH) <input type="checkbox"/> DOT Drug Screen (80306D) <input type="checkbox"/> DOT Breath Alcohol (82075D)			
Please Specify Agency: <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG <input type="checkbox"/> HHS <input type="checkbox"/> NRC			
Reason for Testing: <input type="checkbox"/> Pre- Employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Post Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow Up <input type="checkbox"/>			
NON-DOT DRUG SCREENING			
<input type="checkbox"/> Urine Collection Only (99000) <input type="checkbox"/> 5 Panel External Lab Drug Screen (80306) <input type="checkbox"/> Breath Alcohol Test (82075)			
<input type="checkbox"/> 5 Panel In-House Drug Screen (80305) <input type="checkbox"/> Hair 5 Panel Drug Screen, (80307) <input type="checkbox"/> Nicotine instant (NICOTINE)			
<input type="checkbox"/> 10 Panel In-House Drug Screen (80305B) <input type="checkbox"/> 10 Panel External Lab Drug Screen (80306B) OTHER <input type="checkbox"/> _____			
*All NON-Negative Instant Testing Will Be Sent to Lab for Confirmation Testing			
PHYSICAL EXAM			
<input type="checkbox"/> General Physical (PHYS) <input type="checkbox"/> Pre-Employment Physical (PHYSP) <input type="checkbox"/> Fit for Duty Physical (PHYSF)			
<input type="checkbox"/> Respiratory Clearance Physical (PHYSR) OTHER <input type="checkbox"/> _____ OTHER <input type="checkbox"/> _____			
PFT/RESPIRATOR TEST/QUESTIONNAIRE			
<input type="checkbox"/> PFT with questionnaire (94010, 99245) <input type="checkbox"/> Respirator Questionnaire (99245.R) OTHER <input type="checkbox"/> _____			
IMMUNIZATIONS			
<input type="checkbox"/> Flu Vaccine (FLU) <input type="checkbox"/> Hep B Vaccine (90746) <input type="checkbox"/> Tetanus, Diphtheria (90714)			
<input type="checkbox"/> Tetanus, Tdap (90715) <input type="checkbox"/> Immunization Administration (90741)			
Call for availability <input type="checkbox"/> MMR Vaccine (90707) Call for availability <input type="checkbox"/> Hep A Vaccine (90632) Call for availability <input type="checkbox"/> Varicella (VACVAR)			
LABS			
<input type="checkbox"/> Varicella Zoster IgG (86787) <input type="checkbox"/> Hep B Titer (86706) <input type="checkbox"/> ZPP (84202)			
<input type="checkbox"/> CBC (85025) <input type="checkbox"/> PPD (TB Test) (86580) <input type="checkbox"/> Blood Lead Level (83655)			
<input type="checkbox"/> Venipuncture (36415) <input type="checkbox"/> PPD/TB Gold/Blood (86480) <input type="checkbox"/> MMR Titer (MMRT)			
<input type="checkbox"/> CMP (80053) OTHER <input type="checkbox"/> _____ OTHER <input type="checkbox"/> _____			
TESTING			
<input type="checkbox"/> EKG (93000) <input type="checkbox"/> OSHA Audio Exam (92552) <input type="checkbox"/> Chest X-ray 1 view (71045)			
<input type="checkbox"/> Visual Acuity Test – Snellen (99173) <input type="checkbox"/> Pure Tone Audiometry (92551) <input type="checkbox"/> Chest X-ray 2 view (71046)			
<input type="checkbox"/> Color Vision Exam – Ishihara (99172) <input type="checkbox"/> Biometric Screening (BIO) <input type="checkbox"/> Chest X-ray “B-Read” (76140)			
<input type="checkbox"/> Lift test (97750) OTHER <input type="checkbox"/> _____ OTHER <input type="checkbox"/> _____			
AUTHORIZED BY: We (Employer) are authorizing AppleCare to provide treatment to this employee. By doing so, we acknowledge that we are responsible for payment of any/all services in the event a claim is not filed and paid on our behalf.			
Name (Printed) _____		Signature _____	