SENTARA

Occupational Medicine Account

Authorization for Treatment

Employer:_____ **Account #:**_____

Address:_____

Contact Person:_____ **Phone:**_____

Employee's Name:_____ **SSN (last four):**_____

Substance Abuse Testing: (Note: Pre-hire testing is conducted only between 8 AM and 3:30PM)

- ☐ Instant Drug Screen (if available)
- ☐ Non-DOT 5 Panel Drug Screen
- ☐ Non-DOT 10 Panel Drug Screen
- ☐ DOT Drug Screen
- ☐ Breath Alcohol Testing
- ☐ Hair Drug Screen
- ☐ Collection Only

Reason for Test(s):

- ☐ Pre-employment
- ☐ Random
- ☐ Reasonable Suspicion/Cause
- ☐ Follow-up
- ☐ Post-Accident
- ☐ Return to Duty
- ☐ Other (specify): _____

Instructions to Employee:

If you are scheduled for a drug screen or physical exam, please remember it is helpful to refrain from using the restroom 1-2 hours before your appointment. Please bring a photo identification with you or a company representative/supervisor who can identify you for the staff person collecting the drug specimen. The drug/alcohol test cannot be performed without this positive identification.

Physicals:

- ☐ Pre-employment
- ☐ Annual
- ☐ DOT
- ☐ Re-certification
- ☐ Other:_____

Other Services:

- ☐ Hep B
- ☐ Varicella
- ☐ MMR
- ☐ TDap
- ☐ Flu
- ☐ TB
- ☐ Audiogram
- ☐ EKG
- ☐ Chest X-ray
- ☐ Other: _____

Injury Treatment (check all that apply)

Date of Injury _____

☐ This employee was injured while at work. (Submission of this form is not verification for a workers' compensation injury)

☐ Drug Testing is required

☐ Alcohol Testing is required

☐ This is a temporary employee. Temporary Agency _____

Authorized By:_____ **Title:**_____ **Date:**_____

Signature