

Treatment Authorization

Patient's Name: _____

Date: _____

Company: _____

Phone: _____

Authorized for Treatment by: _____

Print Name: _____

☐ **Workers' Compensation Injury**

Include: ☐ Drug Screen ☐ EBT (Evidential Breath Test)

**DRUG SCREENS MUST BE AT THE CLINIC NO LATER THAN
4:00 P.M.**

☐ **Federal /Non-Federal Drug Screening (select Test & Reason)**
Test:

- ☐ Rapid: 4 _____ 9 _____
☐ Rapid: 5 _____ 10 _____ 12 _____
☐ Federal DOT ☐ Non-Federal: 5 _____ 10 _____
☐ Hair Test

Reason:

- ☐ Pre-Employment Drug Screen
☐ For Cause Drug Screen
☐ Random Drug Screen
☐ Follow-Up Drug Screen
☐ Return to Duty Drug Screen
☐ Post Accident Drug Screen

☐ EBT (Evidential Breath Test) ☐ Federal ☐ Non-Federal

☐ **Pre-Employment Physical**

☐ DOT Physical

☐ Annual Physical

☐ Respirator Physical

Include: ☐ Pulmonary Function Test (PFT)

☐ Respirator Review and Clearance

Include: ☐ Pulmonary Function Test (PFT)

☐ Return to Duty Physical

☐ Fit for Duty Physical

☐ TB Skin Test

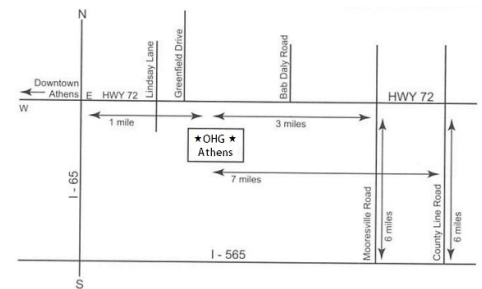
☐ Respirator Fit Test

☐ Audiogram

☐ Other _____

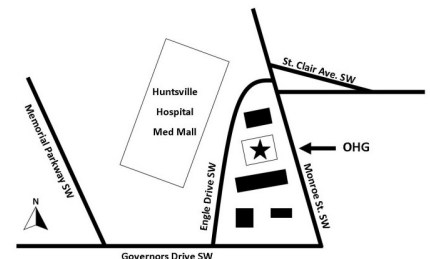
☐ **Occupational Health
Group - Athens**

15243 Greenfield Drive
Athens, AL 35613
(256) 771-0994
Monday - Friday
7:00am – 5:00pm



☐ **Occupational Health
Group - Huntsville**

1104 Monroe Street SW
Huntsville, AL 35801
(256) 265-7000
M - Th 7a - 5:30p
Friday 7a - 5p



☐ **Occupational Health
Group - Madison**

9238 Madison Boulevard
Building 1, Suite 200
Madison, AL 35758
(256) 265-3285
M - Th 7:30a - 5:30p
Friday 7:30a - 5p

