MedExpress®

Employer Authorization Form

Patient Name: _____ **Scheduled Date(s):** _____ **Time:** _____

Company: _____ **Location:** _____

Treatment Authorized by: _____
Name and Title *(please print)*

Signature: _____ **Phone:** _____

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

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 MedExpress lab and MRO

☐ Breath Alcohol Test - Please check: ☐ DOT or ☐ Non-DOT

☐ DOT Urine Drug Screen (5-panel)
Please check one: ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG

☐ Rapid Urine Drug Screen (Non-DOT)
(Please check ☐ 5-panel or ☐ 10-panel)

☐ 5-Panel Standard Urine Drug Screen (Non-DOT)

☐ 10-Panel Standard Urine Drug Screen (Non-DOT)

☐ Custom Panel #: _____

☐ Hair Drug Screen - Please check: ☐ 5-panel or ☐ 5-panel w/exp. opiates

☐ Blood Alcohol Testing*

☐ Oral Fluid Cotinine Test (PA ONLY)

OR

OPTION 2: Using your company paperwork, lab, and MRO

Collection Only

Urine Drug Screen:
☐ DOT
☐ Non-DOT

Hair Drug Screen:
☐ Hair Drug Screen

Rapid Urine Drug Screen (Non-DOT):
(Please check ☐ 5-panel or ☐ 10-panel)

CCF:
☐ On file at center
☐ Donor will arrive with

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

PHOTO ID IS REQUIRED!

Physical Examination:
☐ DOT - Please check ☐ New Certification or ☐ Re-Cert or ☐ Follow-up
☐ Pre-Placement Basic (Non-DOT)
☐ Respirator Questionnaire Clearance
☐ Return-to-Work Evaluation
☐ Special company protocol/form:

☐ Other:

Other Services:
☐ TB skin test/PPD
☐ Hepatitis A vaccine
☐ Hepatitis B vaccine
☐ MMR vaccine
☐ Flu shot
☐ EKG
☐ Other: _____

Labs:
☐ Lead level
☐ Hep B titer (HepBsAB)
☐ MMR titer
☐ CMP
☐ CBC

Additional Services*:
☐ Quantitative Resp. Fit Test
☐ Qualitative Resp. Fit Test
☐ OSHA Pulmonary Function Test
☐ Spirometry Test
☐ Lift Testing
☐ Audiogram OSHA Threshold

**Please call the center to verify availability of test.*

DER/Company contact for results and/or physician call: _____

Preferred communication *(please check all that apply)* ☐ phone ☐ fax (secure) ☐ e-mail ☐ mail

Address: _____ City: _____

State: _____ Zip Code: _____ E-mail: _____

Phone: _____ Ext. _____ Secure Fax: _____

Billing Address (only if different than above):

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Ext. _____ Fax: _____

If billing to carrier: Policy # _____ Effective Dates of Policy: _____ to _____

Company or WC Insurance Carrier: _____