



Medical Authorization

INFORMATION			
Name:		Today's Date:	
Company Name:			Contact:
Phone:	Email:	Fax:	
Worker's Compensation Insurance Carrier:			
Contact:			
I authorize Dr.Paul's Clinic to perform the following procedures (Signature):			
WORK RELATED INJURIES			
<input type="checkbox"/> Work Injury Treatment		<input type="checkbox"/> Evaluation for Cause of Injury	
EVALUATIONS & PHYSICALS			
<input type="checkbox"/> Pre-Placement/Post-Offer		<input type="checkbox"/> OSHA Respirator Questionnaire	
<input type="checkbox"/> Annual Exam		<input type="checkbox"/> Respirator Fit Testing	
<input type="checkbox"/> Respirator Clearance Exam		<input type="checkbox"/> DOT Exam	
DRUG & ALCOHOL SCREENING			
In-House Testing (Immediate Results)		Send Out Testing/DOT/Federal	
DRUG <input type="checkbox"/> Pre-Employment <input type="checkbox"/> Random <input type="checkbox"/> Follow-up <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Return to Duty <input type="checkbox"/> Post-Accident <input type="checkbox"/> Other: _____ <i>*if positive, automatic send out to lab for confirmation</i>	BREATH ALCOHOL TEST <input type="checkbox"/> Random <input type="checkbox"/> Follow-up <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Return to Duty <input type="checkbox"/> Post-Accident <input type="checkbox"/> Other: _____	DRUG <input type="checkbox"/> Pre-Employment <input type="checkbox"/> Random <input type="checkbox"/> Follow-up <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Return to Duty <input type="checkbox"/> Post-Accident <input type="checkbox"/> Other: _____	BLOOD ALCOHOL TEST <input type="checkbox"/> Random <input type="checkbox"/> Follow-up <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Return to Duty <input type="checkbox"/> Post-Accident <input type="checkbox"/> Other: _____
OTHER SERVICES			
<input type="checkbox"/> Audiogram <input type="checkbox"/> Spirometry <input type="checkbox"/> Tuberculosis Test (PPD) <input type="checkbox"/> Hepatitis B Vaccine <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____			