NMC health
Midwest Occupational Medicine

# Authorization Form

Employee Legal Name: _____ DOB: _____

Emp. Email: _____ Emp. Phone: _____ Expires on: _____

Company Name: _____ Authorizer: _____

**Walk-in's Welcome**
**Monday- Friday**
**7a-4p**
**Appt. preferred 4p-5p**

## **STEP 1:** COMPLETE FOR DRUG/BAT TESTING

**Test Reason (Please Check):**
☐Pre-employment ☐Random ☐Post-Accident/Injury
☐Reasonable Suspicion ☐Follow-up (Observed) ☐Return to Duty (Observed)
**DOT Agency (If Applicable)** ☐FMCSA ☐FAA ☐PHMSA ☐FTA ☐FRA ☐USCG

**Drug Screen:**
☐DOT Urine
☐Non-DOT
☐Urine ☐Instant ☐Hair ☐Saliva
☐ Collection Only (must provide CCF)

**Breath Alcohol:**
☐ DOT
☐ Non-DOT

## **STEP 2:** ADDITIONAL SERVICE(S) NEEDED

**Physical:**
☐ DOT Physical
☐ Essential Functions Test (EFT)
☐ Physical (NON-DOT)
☐ Physical w/ EFT
☐ Fit for Duty (Return to Work)
☐ Personal Capacity Profile (PCP) Level: _____

**Respiratory:**
☐ Respiratory Physical
☐ PFT/Spirometry
☐ MEQ/Fit Test
☐ TB Test: ☐Skin ☐Blood
☐ Chest X-Ray

**Audio/Vision:**
☐ Audiogram
☐ Basic Vision (Snellen)
☐ Titmus Vision
☐ Color Vision (Ishihara)
☐ Depth Perception (Fly Test)

**Work Comp:**
☐ Initial Visit: ☐ Drug Screen ☐ BAT
☐ Follow-up Visit (from ER)
☐ Bill Company Direct for Visit
☐ Bill Work Comp Carrier
When available, please provide:
Carrier Name, Address, Phone, Policy #, Claim #, & Adjuster Name (if applicable)

**Other:**
☐ TB Test: ☐Skin ☐Blood
☐ Hep B Series
☐ Hep B Titer
☐ Tetanus Vaccine
☐ Laboratory Blood Testing: _____

**Employer Notes/Requests:**
_____
_____
_____

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