



CUT OFF
 314 Highway 3162
 Cut Off, LA 70433
 Phone: (985) 632-1820 Fax: (985) 632-1824

AUTHORIZATION FORM

Send the form with your employee or **fax** it to: **(985) 632-1824** **DATE:** _____

EMPLOYEE NAME: _____ **DATE OF INJURY:** _____

COMPANY NAME: _____ **PHONE:** _____

COMPANY ADDRESS: _____ **FAX:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **PO/JOB #:** _____

SUPERVISORS NAME: _____ **PHONE:** _____

SEND REPORTS VIA: **FAX** _____ **E-MAIL** _____

MAIL _____ **OTHER** _____

******SERVICES RENDERED ON CHECKED ITEMS ONLY******

<p><u>PHYSICAL EXAMS</u></p> <p><input type="checkbox"/> DOT Physical <input type="checkbox"/> Non-DOT <input type="checkbox"/> Hazardous Waste <input type="checkbox"/> Crane Operators <input type="checkbox"/> Merchant Mariner/CG <input type="checkbox"/> Other _____</p> <p><u>REASON FOR TEST</u></p> <p><input type="checkbox"/> Pre-Employment <input type="checkbox"/> Annual <input type="checkbox"/> Random <input type="checkbox"/> Post-Accident <input type="checkbox"/> Reasonable Cause <input type="checkbox"/> Follow- Up <input type="checkbox"/> Return to Duty <input type="checkbox"/> Other _____</p> <p><u>WORK COMP INJURY</u></p> <p><input type="checkbox"/> Bill Above Named Company <input type="checkbox"/> Bill Insurance Carrier</p> <p><u>Insurance Carrier Info:</u> Name: _____ Address: _____ Phone: _____ Adjuster: _____ Claim #: _____</p> <p>*It is the responsibility of the company to call in a First Report of Injury (Form IA-1) to your workers compensation insurance carrier.</p>	<p><u>URINE DRUG SCREEN</u></p> <p><input type="checkbox"/> DOT (CDL) * <input type="checkbox"/> Non-DOT <input type="checkbox"/> DOT Collection Only * <input type="checkbox"/> Non-DOT Collection Only <input type="checkbox"/> Quick Screen <input type="checkbox"/> OBSERVATION required for drug screen</p> <p><u>HAIR SAMPLE DRUG SCREEN</u></p> <p><input type="checkbox"/> Psychemedics <input type="checkbox"/> Quest</p> <p><u>ALCOHOL TESTING</u></p> <p><input type="checkbox"/> DOT <input type="checkbox"/> Non-DOT <input type="checkbox"/> Breath <input type="checkbox"/> Saliva</p> <p><u>*ALL DOT DRUG SCREENS MUST SPECIFY TESTING AGENCY</u></p> <p><input type="checkbox"/> HHS <input type="checkbox"/> NRC <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG</p>	<p><u>TEST</u></p> <p><input type="checkbox"/> Audiogram <input type="checkbox"/> Pulmonary <input type="checkbox"/> Respirator Fit (Type of Mask) _____</p> <hr/> <p><input type="checkbox"/> Chest X-Ray (1 view) <input type="checkbox"/> Chest X-Ray (2 views) <input type="checkbox"/> EKG <input type="checkbox"/> Lumbar X-Ray (2 views) <input type="checkbox"/> Lumbar X-Ray (3 views) <input type="checkbox"/> Lumbar X-Ray (5 views) <input type="checkbox"/> Eye Exam Only <input type="checkbox"/> Cervical X-Ray (2 views) <input type="checkbox"/> Cervical X-Ray (5 views) <input type="checkbox"/> Other: _____</p> <p><u>INJECTIONS</u></p> <p><input type="checkbox"/> Flu Vaccine <input type="checkbox"/> Hepatitis B Vaccine <input type="checkbox"/> Tetanus Shot <input type="checkbox"/> TB Skin Test <input type="checkbox"/> Other: _____</p> <p><u>LABORATORY TEST</u></p> <p><input type="checkbox"/> Industrial Chem <input type="checkbox"/> CBC <input type="checkbox"/> Lead Blood <input type="checkbox"/> ZPP (Zinc) <input type="checkbox"/> HIV <input type="checkbox"/> Other: _____</p>
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AUTHORIZED BY: _____ **TITLE:** _____
(PRINT NAME) (REQUIRED)