Medical Authorization Form — Flagstaff Industrial Medicine

Patient Name:_____ **Appt. Time:_____** **Date:_____**

Company:_____ Phone#:_____

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

Authorized by:_____ Date:_____
An officer or properly designated person Signature Print

By signing this authorization the above referenced company acknowledges and agrees that it is fiscally responsible for all incurred charges, whether work related or non-work related.

Work-Related Injury/Illness (check box)	☐ Evaluation ☐ Treatment Specify body part:_____ *If this incident is deemed work-related, the authorizing organization will be responsible for charges prior to written notification.*
Drug Screen (check box)	☐ **DOT** ☐ **Non-DOT** (☐ Urine Lab ☐ Rapid Urine Drug Screen) ☐ Post-Offer ☐ Post accident ☐ Reasonable suspicion ☐ Random ☐ Follow-up ☐ Witnessed/observed ☐ Employee to pay
Saliva Alcohol Screen Non DOT (check box)	☐ Post-Offer ☐ Post accident ☐ Reasonable suspicion ☐ Random ☐ Follow-up ☐ Witnessed/observed ☐ Employee to pay
Physical Examination (check box)	☐ Post-offer ☐ DOT ☐ Annual ☐ Respiratory clearance ☐ Toxic ☐ Other:_____ ☐ Employee to pay
Immunization (check box)	☐ Hep A ☐ Hep B ☐ Flu ☐ TB ☐ Tetanus ☐ MMR ☐ Other:_____ ☐ Employee to pay
Other Services (check box)	☐ PFT ☐ Audiometry ☐ Post-offer job screen ☐ Lab:_____ ☐ Other:_____

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Please call for an appointment.

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