Medical Authorization

INFORMATION		
Name:	Today's Date:	
Company Name:		Contact:
Phone:	Email:	Fax:
Worker's Compensation Insurance Carrier:		
Contact:		
I authorize Liberty Urgent Care to perform the following procedures (Signature):		

WORK RELATED INJURIES	
☐Work Injury Treatment	☐Evaluation for Cause of Injury

EVALUATIONS & PHYSICALS	
☐Pre-Placement/Post-Offer	☐OHSA Respirator Questionnaire
☐Annual Exam	☐Respirator Fit Testing
☐Respirator Clearance Exam	☐DOT Exam

DRUG & ALCOHOL SCREENING

In-House Testing (Immediate Results)		Send Out Testing/DOT/Federal	
DRUG	**BREATH ALCOHOL TEST**	**DRUG**	**BLOOD ALCOHOL TEST**
☐Pre-Employment	☐Random	☐Pre-Employment	☐Random
☐Random	☐Follow-up	☐Random	☐Follow-up
☐Follow-up	☐Reasonable Suspicion	☐Follow-up	☐Reasonable Suspicion
☐Reasonable Suspicion	☐Return to Duty	☐Reasonable Suspicion	☐Return to Duty
☐Return to Duty	☐Post-Accident	☐Return to Duty	☐Post-Accident
☐Post-Accident	☐Other:_____	☐Post-Accident	☐Other: _____
☐Other:_____		☐Other:_____	
**if positive, automatic send out to lab for confirmation*			

OTHER SERVICES

☐Audiogram
☐Spirometry
☐Tuberculosis Test (PPD)
☐Hepatitis B Vaccine
☐Other: _____
☐Other: _____