DEPAUL COMMUNITY HEALTH CENTERS

`Authorization Form

Patient name: _____ Social Security Number: _____

Employer: _____ Date of Birth: _____

Employer Street Address: _____

Work Related:

□ Injury □ Illness Date of Injury _____

Physical Examination

□ Pre-placement □ DOT Physical □ Respiratory Physical □ Hazmat Physical

Other Testing

□ PFT □ Audiogram □ Fit Testing □ EKG □ Titumus □ Ishara □ PPD □ Quantiferon

Substance Abuse Testing*(check all that apply)

□ DOT Drug Screen □ Breath Alcohol □ Collection Only □ Hair Collect

□ NON-DOT drug screen □ Rapid drug screen □ Other_____

Type of Abuse Testing

□ Pre-placement □ Reasonable Cause □ Post- Accident □ Random □ Follow-up

□ Direct Observation

Vaccines

□ Hepatitas Vaccine □ □ MMR Vaccine □ Other _____

* Please make sure specific services are marked off.

Special Instructions/ Comments:

_____

By signing this authorization, the said employer acknowledges full responsibility for payment for ALL services related to examinations, screening diagnostic testing and treatment and or medications deemed necessary by the treating physician for the authorized individual named in this form unless it is previously requested to collect payment at time of service from the individual. It is understood that the services will be paid for in full upon receipt of billing for all amounts due. It is also understood that the employer will be responsible for payment of all services related to injury or illness care of the employee if said case is the determined work related or not, or if the claim is denied by the workers compensation insurance carrier.

AUTHORIZED BY: _____ Title: _____

DEPAUL COMMUNITY HEALTH CENTERS

Phone: _____ Date: _____