HealthCare for Business

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Treatment Authorization Form

Employee Information

Patient Name—Last, First, MI	☐ M ☐ F	SS# / Employee ID#	Date of Birth
Address	City, State, Zip		Phone

Company Information

Company/Managed Care Organization Information

Company	Phone	Fax
Address	Email	
MCO	Authorized by Signature—REQUIRED	

Injury Treatment

Date/Time of Injury	Type of Injury

Please attach a copy of functional job description if necessary.

Physical Examination

☐ Pre-Placement Post Offer ☐ Annual ☐ Return to Work ☐ CDL ☐ T-8 ☐ Other _____

Requested Testing

Substance Abuse Testing

Please specify type—check all that apply

☐ **Drug Screen** ☐ **Alcohol Screen** ☐ DOT/SAMSHA ☐ Non-DOT

Reason for testing

___DOT Consortium
___Pre-placement
___Post-injury
___Post-accident
___Random
___Reasonable Suspicion
___Periodic / Follow up

Other Testing

Please specify type—check all that apply

☐ Audiogram ☐ Labs—please specify _____

☐ PFT ☐ Other—please specify _____

Thank you for choosing HealthCare for Business for all your Employee Testing needs!