



NECA/IBEW 68

EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT

(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

PATIENT NAME: _____

SSN: N/A

COMPANY NAME: _____

DATE OF BIRTH: N/A

ADDRESS / LOCATION #: _____

DATE OF INJURY: _____

TEMPORARY STAFFING AGENCY: N/A

WORK-RELATED INJURY N/A ILLNESS

Post Accident Substance Abuse Testing:

- Drug Screen
- Breath Alcohol
- Urine Collection Only

TEST TYPE

- DOT Regulated
- Non-Regulated

BILLING

- Bill company for services
- Employee to pay at time of service
- Bill Workers' Compensation Carrier

Carrier: _____
 Policy #: _____
 Phone #: _____
 Address: _____

PHYSICAL EXAMINATIONS

Job Title: _____

- DOT Preplacement
- DOT Recertification
- Physical Exam
- Asbestos
- Respirator
- Hazmat
- Other _____

- HPE
- Audiogram

TEST TYPE

- Preplacement
- Annual
- Exit

SUBSTANCE ABUSE TESTING

- Regulated
- Non-Regulated
- Urine Collection Only
- Rapid Test
- eScreen
- Hair Collection
- Breath Alcohol

TEST TYPE

- Preplacement Customer Request
- Random
- Reasonable Suspicion
- Post Accident
- Periodic
- Follow-up
- Return to Duty

Authorized By: _____

Title: _____

Phone: _____

Date: _____

Patient Must Receive a "Custody and Control Form for Rapid Drug Screening"