SouthStar URGENT CARE

Please complete this form and send with your employee at time of service.

MEDICAL AUTHORIZATION

Employee Name: _____ **Date:** _____

Company Name: _____ **Contact Name:** _____

Social Security #: _____ **Job Number/Name:** _____

(Please Check all services requested)

Injury Treatment: **Type:** _____

Return to Work Clearance: **Reason:** _____

Physical Exam:

- ( ) DOT CDL
- ( ) DOT Coast Guard
- ( ) NON DOT physical
- ( ) Hazmat Physical
- ( ) Other: _____

Reason:

- ( ) Pre-Employment
- ( ) Semi-Annual
- ( ) Annual
- ( ) Re-Certification
- ( ) Other: _____

( ) **Functional Capacity Test:**

Breath Alcohol Test:

( ) NON DOT ( ) DOT ( ) DISA

Hair Test:

( ) Hair test our form ( ) Hair test collection only

Drug Screen:

- ( ) DOT Drug Screen
- ( ) NON DOT Drug Screen
- ( ) Drug Screen Collection Only ( ) DISA
- ( ) 10 Panel Quick Test
- ( ) 5 Panel Quick Test

Reason:

- ( ) Pre-employment ( ) Follow up/ observed
- ( ) Random
- ( ) Annual ( ) Return to duty/ observed
- ( ) Post Accident
- ( ) Reasonable Suspicion
- ( ) Other: _____

Respirator Fit Test: ( ) Qualitative (smoke tube) ( ) Quantitative (PortaCount)

Mask# 1:_____ **Mask# 2:** _____ **Mask# 3:** _____

( ) Pulmonary Function Test ( ) OSHA Questionnaire Only

( ) Audiogram

( ) Laboratory Tests: _____

( ) Other:_____

Authorized Signature and Phone Number: