

Authorization for Treatment

Authorization for Medical Services

Employee Should Report to:



9601 S. Sepulveda Blvd. Los Angeles, CA 90045 at 96th Street ~ LAX
Tel: 310-215-6020 Fax Authorization: 310-491-7077 ~ Transportation: 310-215-6000

Employee Information

1.

Employee Name: _____
Authorized Date: _____ Job Desc: _____
Injury Date: _____ Injury Time: _____

Employer Information

2.

Company: _____ Dept/Project: _____
Authorized By: _____ Title: _____
Phone: _____ Phone Ext: _____

Injury / Illness Treatment

3.

<input type="checkbox"/> Work Injury Treatment	~ <i>Additional Services to Include:</i>
<input type="checkbox"/> Illness - Bill Employer	
<input type="checkbox"/> Illness - Bill Patient	
<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Describe Injury: _____	
	<input type="checkbox"/> Include - Non-DOT Drug Test
	<input type="checkbox"/> Include - DOT Drug Test
	<input type="checkbox"/> Include - Breath Alcohol Test

Physical Exams

<input type="checkbox"/> Fit for Duty / Return to Work	~ <i>Annual Testing:</i>
<input type="checkbox"/> Pre-Placement Physical	
<input type="checkbox"/> DMV / DOT Physical	
<input type="checkbox"/> Respirator Physical	
<input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Audio / Hearing Test
	<input type="checkbox"/> TB Testing
	<input type="checkbox"/> Other: _____

Substance Abuse Testing

~ *Choose One:*

<input type="checkbox"/> Post Accident	<input type="checkbox"/> Random	<input type="checkbox"/> Pre-Placement
<input type="checkbox"/> Follow-up	<input type="checkbox"/> Return to Duty	<input type="checkbox"/> Reasonable Suspicion

~ *Specify Type of Test to be Performed:*

<input type="checkbox"/> DOT Urine Drug Screen	<input type="checkbox"/> Non DOT Drug Screen
<input type="checkbox"/> Breath Alcohol (BAT)	<input type="checkbox"/> Hair Collection Drug Screen