DOT Physical Authorization Form

DIRECTIONS:
Complete all Sections A - D entirely
(Only services marked on this form will be completed)

**** All services require photo identification to be provided by employee at time of service.**

This is authorization to provide medical services to:_____ **DOB**_____ **SS#** _____

(Print Patient Name Above)

Section A: Employer Information

Employer Name:

Address:

Phone #

Fax #

Third Party Administrator

Employer Name:

Address:

Phone #

Fax #

Section B: Physical Examination

Donor will bring Physical Exam Form ❑ Yes ❑ No

❑ DOT Physical Exam

These Additional Services MAY BE Required

Will Employer pay for the additional Services ?

❑ Yes ❑ No

❑ Spirometry – Pulmonary Function
❑ Audiometry
❑ Vision Test - Keystone
❑ Glucose Finger Stick
❑ Electrocardiogram (EKG)

Section C: Urine Drug/Alcohol Tests

Urine Drug Screens
❑ Collection Only / Donor will bring COC
Florida Drug Free Workplace
❑ 5 Panel HRS
❑ 8 Panel HRS
❑ 10 Panel HRS
DOT
❑ DOT / NIDA

Alcohol Testing
Lake Ella, Appleyard, North & Mahan Locations Only

❑ DOT Breath Alcohol Test
❑ Non – DOT Breath Alcohol Test

Additional Comments/ Notes:

Section D: Authorization Information

Print Name of Authorizer:

Fax or Mail results to:

Authorizer Signature:

Title:

Billing: Please mark responsible billing party
❑ Bill Employer
❑ Bill Third Party Administrator

Phone #

Date:

For Patients First Use Only: Phone Auth received by:

Date & Time