

**AUTHORIZATION FORM**

**Send** the form with your employee or **fax** it to: (337) 534-8268      **DATE:** \_\_\_\_\_

**EMPLOYEE NAME:** \_\_\_\_\_ **DATE OF INJURY:** \_\_\_\_\_

**COMPANY NAME:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**COMPANY ADDRESS:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_ **PO/JOB #:** \_\_\_\_\_

**SUPERVISORS NAME:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**SEND REPORTS VIA:**  **FAX** \_\_\_\_\_  **E-MAIL** \_\_\_\_\_

**MAIL** \_\_\_\_\_  **OTHER** \_\_\_\_\_

\*\*\***SERVICES RENDERED ON CHECKED ITEMS ONLY**\*\*\*

<p><b><u>WORK COMP INJURY</u></b></p> <p><input type="checkbox"/> Bill Above Named Company</p> <p><input type="checkbox"/> <b>Bill Workers Comp Insurance Carrier:</b> It is the responsibility of the company to call in a First Report of Injury (Form IA-1) to your workers' compensation insurance carrier. Please provide carrier info and claim number below.</p> <p style="padding-left: 40px;"><b>Workers Comp Insurance Carrier</b></p> <p style="padding-left: 40px;">Company: _____</p> <p style="padding-left: 40px;">Phone: _____</p> <p style="padding-left: 40px;">Address: _____</p> <p style="padding-left: 40px;">Adjustor: _____</p> <p style="padding-left: 40px;">City: _____</p> <p style="padding-left: 40px;">State: _____ Zip: _____</p> <p style="padding-left: 40px;">Claim No.: _____</p> <p><b>Your assistance in providing the claim number for this injury will expedite the management of this injury and the processing of claims.</b></p>	<p><b><u>DRUG SCREEN</u></b></p> <p><input type="checkbox"/> DOT</p> <p><input type="checkbox"/> Non-DOT</p> <p><input type="checkbox"/> DOT Collection</p> <p><input type="checkbox"/> Non-DOT Collection</p> <p><input type="checkbox"/> Quick Screen</p> <p><input type="checkbox"/> Hair</p> <p><input type="checkbox"/> Other _____</p> <p><b><u>ALCOHOL TESTING</u></b></p> <p><input type="checkbox"/> DOT</p> <p><input type="checkbox"/> Non-DOT</p> <p><input type="checkbox"/> Breath</p> <p><input type="checkbox"/> Saliva</p> <p><input type="checkbox"/> Other _____</p> <p><b><u>REASON FOR TEST</u></b></p> <p><input type="checkbox"/> Post Accident</p> <p><input type="checkbox"/> Pre-employment</p> <p><input type="checkbox"/> Random</p> <p><input type="checkbox"/> Other _____</p> <p><b><u>PHYSICAL EXAMS</u></b></p> <p><input type="checkbox"/> Non-DOT</p> <p><input type="checkbox"/> DOT</p> <p><b><u>OTHER</u></b></p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p>
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**AUTHORIZED BY:** \_\_\_\_\_ **TITLE:** \_\_\_\_\_

(PRINT NAME)  (REQUIRED)