



Analyzed Drug Testing

Authorization Form for Services



Date of Service: _____

<u>Donor Information</u>	
Category:	<input type="checkbox"/> DOT Personnel <input type="checkbox"/> NON-DOT Personnel <small>(check one)</small>
Name:	_____
SS:	_____
CDL#:	_____
<small>CDL # IS REQUIRED FOR ALL FMCSA MANDATED TESTS ONLY</small>	
Issuing State:	_____
Employee ID #	_____
Donor Notified:	Date: _____
	Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM

<u>Company Information</u>	
Company Name:	_____
Phone Number:	_____
DER Name:	_____
DER Signature:	_____
DER Email:	_____
Billing (A/P) Email:	_____
BILL TO:	<input type="checkbox"/> Third Party Administrator <input type="checkbox"/> Direct Billing <input type="checkbox"/> Credit Card Pay
Test Authority:	<input type="checkbox"/> HHS <input type="checkbox"/> NRC <input type="checkbox"/> DOT MODE: <input type="checkbox"/> FMCSA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA

Reason for Test			
Please Check the Appropriate Test			
<input type="checkbox"/> PRE-EMPLOYMENT	<input type="checkbox"/> RANDOM	<input type="checkbox"/> POST-ACCIDENT	<input type="checkbox"/> RETURN TO DUTY (OBSERVED)
<input type="checkbox"/> REASONABLE SUSPICION	<input type="checkbox"/> PERIODIC (NONDOT ONLY)	<input type="checkbox"/> PRE-ACCESS	<input type="checkbox"/> FOLLOW-UP (OBSERVED)
<input type="checkbox"/> OTHER _____			

Requested Services			
Please Check the Requested Testing to be Conducted			
<input type="checkbox"/> DOT DRUG SCREEN	<input type="checkbox"/> DOT BREATH	<input type="checkbox"/> NON-DOT DRUG SCREEN (URINE)	<input type="checkbox"/> NON-DOT BREATH
<input type="checkbox"/> 12 PANEL INSTANT DRUG TEST (URINE)	<input type="checkbox"/> 10 PANEL INSTANT DRUG TEST (SALIVA)	<input type="checkbox"/> HAIR FOLLICLE	
<input type="checkbox"/> DOT PHYSICAL	<input type="checkbox"/> NON-DOT PHYSICAL		

Additional Services		
<input type="checkbox"/> Direct Observation	<input type="checkbox"/> DNA Test	<input type="checkbox"/> Oral Fluid/Saliva/QED

**ALL DONORS MUST HAVE A VALID GOVERNMENT ISSUED PICTURE ID WHEN THEY REPORT TO THE COLLECTION SITE FOR TESTING.
NO ID = NO TEST**

Once you arrive at the clinic for a drug and/or alcohol test, you may not leave the facility for any reason. Failure to remain at the site until the collection(s) is completed will result in a REFUSAL to test which has the same consequences as a positive result.

FACILITY USE ONLY **DONOR ARRIVAL:** Date: _____ Time: _____ AM PM