



Employer Authorization Form

(Complete this form and present at the time of service)

Date:

Patient Name:

Company: _____ Phone: _____ Contact: _____

Required Services (check all that apply):

Work Related

- ☐ Worker's Compensation Injury Treatment:
Date of Injury: _____
Type of Injury: _____

- ☐ Post-accident Drug Screen required

Physical Examination

- ☐ DOT Physical
☐ Physical Strength Test / FCE
☐ WorkSteps
☐ Non-DOT Physical
☐ Physical
(other): _____

Drug Screen/Breath Alcohol Testing

- ☐ Prehire / Random / Reasonable
☐ DOT Drug Test
☐ Non-DOT Drug Test
☐ Instant (5 Panel / 10 Panel)
- ☐ Breath Alcohol
☐ DOT
☐ Non-DOT

Special Examination

- | | |
|---|---|
| <input type="checkbox"/> Audiogram | <input type="checkbox"/> Blood Lead Level |
| <input type="checkbox"/> OSHA Questionnaire | <input type="checkbox"/> HEP B Immunization |
| <input type="checkbox"/> Fit Test | <input type="checkbox"/> TB Test |
| <input type="checkbox"/> Spirometry | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Hair Follicle | <input type="checkbox"/> Flu Shot |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> |

Office is Located across from La Carreta Restaurant



Laredo Occupational Center

*"Shaping the future of
Occupational Medicine"*

Located at:

**9114 McPherson Rd
STE 2508
Laredo, TX 78045**

**O: 956-568-3638
F: 956-568-3665**