



EMPLOYER DRUG
TESTING SOLUTIONS

Employer Authorization Form

Name of Company: _____

Name of Employee for Testing: _____ Date: ___/___/___

Authorized By (Print Name): _____ Callback #: (____)_____

Please fill out the below information with an "X" as applicable.

Service(s) Ordered:

Physicals –

DOT PHYSICAL:

Test Type: NEW RECERT

NON-DOT PHYSICAL:

Test Type: NEW RETURN TO DUTY OTHER: _____

Drug & Alcohol Testing -

Test Reason: PRE-EMPLOYMENT RANDOM POST-ACCIDENT RTW
REASONABLE SUS. FOLLOW UP

Service(s):

DOT URINE ONLY

DOT BREATH ALCOHOL ONLY

DOT URINE & ALCOHOL

NON-DOT URINE ONLY

Specify Panel: 5 PANEL 6 PANEL 10 PANEL

NON-DOT BREATH ALCOHOL ONLY

NON-DOT URINE & ALCOHOL

Specify Panel: 5 PANEL 6 PANEL 10 PANEL

RAPID DRUG TEST

Rapid Drug Test Type: 5 PANEL 6 PANEL 10 PANEL

ORAL SWAB

Oral Swab Test Type: 5 PANEL 6 PANEL 10 PANEL

HAIR FOLLICLE COLLECTION

Hair Drug Test Type: 5 PANEL 6 PANEL 10 PANEL

IS EMPLOYEE RESPONSIBLE FOR CHARGES AT TIME OF SERVICE? "X" IF "YES".

If you have any questions or special requests for testing, please call (417)-258-3323.