KING'S DAUGHTERS
PHYSICIAN CLINICS

Employer Authorization form

Employee Name _____ Today's Date _____

Date of Birth_____ Phone:_____ Social:_____

EMPLOYER INFORMATION (*please print*)

Company Name _____ Phone # _____

Address _____ Fax # _____

Person Authorizing Visit _____ Title _____

Signature of Person Authorizing Visit _____ Date _____

Email _____ Direct Phone # _____

REQUESTED SERVICES

☐ DOT Physical ☐ Pre-employment Physical ☐ Physical ☐ Return to Work Physical
☐ OSHA Questionnaire ☐ chest x-ray ☐ TB Skin Test
Immunizations _____ Other _____

☐ **Treatment for Injury**
Date & Time of Injury/ Illness _____
COMMENTS: _____

DRUG AND OR ALCOHOL TESTING (*please specify reason*)

REASON FOR DRUG AND ALCOHOL TESTING:

☐ PreEmployment ☐ Random ☐ Reasonable Suspicion ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Observed

Breath Alcohol:
☐ Breath Alcohol Test DOT
☐ Breath Alcohol Non DOT

Drug Testing:
☐ DOT
☐ Non DOT

☐ escreen eCup 5 panel
☐ escreen xCup 10 panel
☐ collection only
Comments:_____

BILLING INFORMATION (*please print*)

☐ **Bill Company**
Company Billing Address (if different from above)_____
Billing Contact Person _____ Phone # _____

☐ **Bill Worker's Comp Carrier**

Worker's Comp Carrier _____ Phone # _____

Address _____ Claim # _____

Adjuster name _____ Light Duty Available? ☐ Yes ☐ No

For Internal Use Only:
Results Sent to Employer [ ] KDMC Staff: _____ Date:_____