Proven
Occupational Health

10330 S. Roberts Rd. Palos Hills, IL 60465
Hours: Monday - Friday 7 a.m. - 5 p.m.
Ph 708-581-3570 · Fax 708-581-3580

Medical Treatment Authorization Form

Company Name _____

Employee's Name _____ **SS#** _____

Company Telephone # _____ **Fax #** _____

The above individual is scheduled on _____ (Date) at _____ (Time)

Please Check Services Needed

- ❑ Diagnose & Treatment
- ❑ Physical Examination
- ❑ Pre-Placement Non-DOT
- ❑ Pre-Placement DOT
- ❑ Return to Work
- ❑ Annual Non-DOT
- ❑ Recertification DOT
- ❑ Executive Physical

Please Check the Type of Drug Test Needed

- ❑ Urine Drug Screen (Non-DOT) (Chain of Custody)
- ❑ Urine Drug Screen DOT
- ❑ Urine Drug Screen (Collection Only) Laboratory:_____
- ❑ Rapid Urine Drug Screen
- ❑ Hair Analysis Test
- ❑ Breath Alcohol Test
- ❑ Blood Alcohol Test

Please Check the Reason for The Drug Test

❑ Pre-Placement ❑ Random ❑ Post-Accident ❑ Reasonable Suspicion

Please Check Any Additional Services Needed

- ❑ Pulmonary FunctionTest (PFT)
- ❑ Audiogram/Hearing Test
- ❑ Hepatitis B Vaccine (3 injections)
- ❑ Hepatitis B Antibody Test
- ❑ Hepatitis B Booster

Company Representative _____

Return Results by: ❑ Fax ❑ Phone ❑ Email

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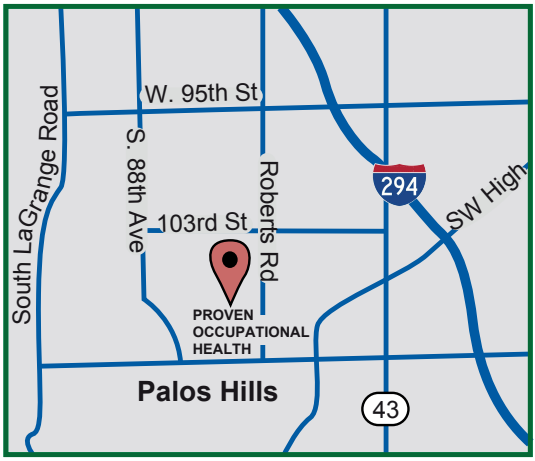

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