

**Occupational Health & Wellness  
2510 Hwy 127 Kathleen, Ga 31047  
(478) 988-1853 Fax (478) 988-1858**

**AUTHORIZATION FOR EXAMINATION OR TREATMENT**

Employee Name: \_\_\_\_\_ SS# \_\_\_\_\_  
 Company Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ Location #: \_\_\_\_\_  
 Authorized By (Please Print): \_\_\_\_\_ Title: \_\_\_\_\_  
 Phone# \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**INJURY TREATMENT**

Work Related: \_\_\_\_\_ injury \_\_\_\_\_ illness  
 Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_

**POST ACCIDENT SUBSTANCE ABUSE TESTING**

<input type="checkbox"/> 5 Panel	<input type="checkbox"/> Non DOT Collection
<input type="checkbox"/> 7 Panel	<input type="checkbox"/> DOT Collection
<input type="checkbox"/> 10 Panel	<input type="checkbox"/> Quick Test - 5 Panel
<input type="checkbox"/> DOT / NIDA 5 Panel	<input type="checkbox"/> Quick Test - 8 Panel
<input type="checkbox"/> Oral Fluid - 6 Panel	<input type="checkbox"/> Quick Test - 10 Panel
<input type="checkbox"/> Hair - 5 Panel	<input type="checkbox"/> Breath Alcohol
<input type="checkbox"/> Hair Collection	

**PRE-EMPLOYMENT EVALUATION**

Physical Exam  
 Post-After Placement / Agility Test

**PRE-EMPLOYMENT SUBSTANCE ABUSE TESTING**

<input type="checkbox"/> 5 Panel	<input type="checkbox"/> Hair Collection
<input type="checkbox"/> 6 Panel	<input type="checkbox"/> Non DOT Collection
<input type="checkbox"/> 7 Panel	<input type="checkbox"/> DOT Collection
<input type="checkbox"/> 10 Panel	<input type="checkbox"/> Quick Test - 5 Panel
<input type="checkbox"/> DOT / NIDA 5 Panel	<input type="checkbox"/> Quick Test - 8 Panel
<input type="checkbox"/> Oral Fluid - 6 Panel	<input type="checkbox"/> Quick Test - 10 Panel
<input type="checkbox"/> Hair - 5 Panel	<input type="checkbox"/> Breath Alcohol

**SUBSTANCE ABUSE TESTING - ONLY**

<input type="checkbox"/> Pre-Employment	<input type="checkbox"/> Random
<input type="checkbox"/> Post-Accident	<input type="checkbox"/> Return to Duty
<input type="checkbox"/> Reasonable Susp.	<input type="checkbox"/> Follow-up

<input type="checkbox"/> 5 Panel	<input type="checkbox"/> Non DOT Collection
<input type="checkbox"/> 7 Panel	<input type="checkbox"/> DOT Collection
<input type="checkbox"/> 10 Panel	<input type="checkbox"/> Quick Test - 5 Panel
<input type="checkbox"/> DOT / NIDA 5 Panel	<input type="checkbox"/> Quick Test - 8 Panel
<input type="checkbox"/> Oral Fluid - 6 Panel	<input type="checkbox"/> Quick Test - 10 Panel
<input type="checkbox"/> Hair - 5 Panel	<input type="checkbox"/> Breath Alcohol
<input type="checkbox"/> Hair Collection	

**DEPARTMENT OF TRANSPORTATION**

Pre-Employment DOT Physical  
 Follow-Up DOT Physical  
 Re-Certification DOT Physical

**DOT SUBSTANCE ABUSE TESTING**

<input type="checkbox"/> Random	<input type="checkbox"/> Pre-Employment
<input type="checkbox"/> Post Accident	<input type="checkbox"/> Follow-Up
<input type="checkbox"/> Reasonable Susp.	<input type="checkbox"/> Return to Duty
<input type="checkbox"/> DOT/NIDA 5 Panel	<input type="checkbox"/> DOT Urine Collection
<input type="checkbox"/> Breath Alcohol Test	

**SPECIAL PHYSICAL EXAMINATION**

Respirator  Annual  
 Return to Work  
 Asbestos  
 Other: \_\_\_\_\_

**OTHER SERVICES**

Audiometry  
 Visual Acuity  
 Spirometry  
 Respirator Questionnaire  
 Respirator Fit Test  
 Hepatitis B Shot  
 TB Skin Test  
 X-Ray(s)  
 Type: \_\_\_\_\_  
 Hepatitis B Titer  
 Background Check  
 MVR  
 Other: \_\_\_\_\_

**BILLING INFORMATION**

Employee to pay charges at time of service  
 Employer/Company to pay charges Workers' Compensation

Insurance Co: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Policy #: \_\_\_\_\_  
 Claim #: \_\_\_\_\_  
 Other: \_\_\_\_\_

**HOURS OF OPERATION**

**Monday - Friday 8 a.m. - 5 p.m.**