



Occupational Drug Screens, Physicals, Breath Alcohol Testing, & Other Occupational Health Services

EMPLOYER AUTHORIZATION FOR TREATMENT AND BILLING

Please note: Payment is expected at the time services are rendered, **unless prior arrangements have been made.**

Photo identification is required for Drug and Alcohol Testing and for DOT Physicals. For questions or to schedule an appointment for these services, please contact the Clinic directly or the Occupational Health Department at **(989) 912-6483 or (989) 912-6507**

Employee Name: _____

Employee Donor ID Number: _____ Date of Birth: _____

Employer's name and address: _____

Billing address (if different from above): _____

The above named employee is authorized to receive the following services:

____ DOT physical ____ Employment physical (Non DOT) ____ Bus Driver Physical
____ DOT urine drug screen ____ DOT drug screen, **collection only** ____ DOT breath alcohol test

(If D.O.T. please specify DOT designation as required by D.O.T. Regulations 49 CFR Part 40)

FMCSA FRA USCG FAA FTA PHMSA

____ Occupational urine drug screen (Non-DOT): ____ Occupational drug screen, **collection only**

5panel 9panel 10panel (indicate 6633N on CCF) Other _____

____ Occupational breath alcohol test (Non-DOT) ____ TB Skin Test

____ Other (specify) _____

Must indicate reason for drug or alcohol screen or physical exam:

____ Pre-employment ____ Random ____ Post-Accident ____ Reasonable Cause
____ Return-to-duty ____ Follow-up ____ Other _____

Signature of authorized individual: _____ Title: _____

Date: _____ Time (if applicable) _____ Phone number to contact: _____

Consent for Service and Authorization of Release of Information

Consent to service: I hereby consent to Aspire Rural Health Systems and the attending physician for examination and/or ancillary testing, including drug or alcohol screening.

Authorization to release information: I hereby authorize Aspire Rural Health Systems to release any information, which may contain protected health information, pertaining to the services indicated above to my employer, prospective employer, or employer's agent.

Signature: _____ Date: _____

Witness: _____ Date: _____