Occupational Health Services
Employer Authorization

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

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, please contact the Occupational Health Department at **(989) 912-6483** or **occhealth.dpt@aspirerhs.org**.

Employee Name: _____

Employee Donor ID Number: _____ Date of Birth: _____

Employer's name and address: _____

Billing address (if different from above): _____

SERVICES AUTHORIZED (Check all that apply)

PHYSICALS: DOT Physical ____ Employment Physical (Non-DOT) ____ Other: _____

DOT DRUG TESTING: DOT Urine Drug Screening _____ DOT Collection Only _____

DOT Agency (Required): FMCSA ____ FRA ____ USCG ____ FAA ____ FTA ____ PHMSA ____

NON-DOT Drug Testing: Drug Screen ____ Collection Only ____

PANEL (Required): 5 Panel ____ 9 Panel ____ 10 Panel (6633N) ____ Other: _____

ALCOHOL TESTING: DOT Breath Alcohol Test ____ NON-DOT Breath Alcohol Test ____

OTHER SERVICES: TB Skin Test ____ Other: _____

Reason for Services (Required):

____ 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 System and the attending provider for examination and/or ancillary testing, including drug or alcohol screening.

Authorization to release information: I hereby authorize Aspire Rural Health System 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: _____