EMPLOYER SERVICE AUTHORIZATION

Employer: _____ (please print)

Person to Receive Results: _____

Receive Results: Select One
Phone: _____
Email: _____
Fax: _____

Employee Information _____
Name DOB

_____
Address City/State/Zip Phone

VISIT REASON

☐ Pre-Employment ☐ Random ☐ Return to Work/Fit for Duty ☐ Annual Testing

☐ Reasonable Suspicion ☐ Medical Follow Up ☐ Other: _____

☐ Work-Related Injury/Illness/Workers' Compensation *(Complete the Work Comp section on page 2 of this form.)*

SERVICE(S) TO BE PERFORMED and BILLED TO EMPLOYER (please mark all applicable services)

	DOT Physical/Bus Driver Physical		Non-DOT Urine Drug Screen, with Confirmation send off, if needed
	Pre Employment Physical (Non DOT)		Non-DOT Breath Alcohol
	Physical Capacity Profile Test		Collection Only – Urine Drug Screen
	Physical for Foster Care or Child Care Personnel		Hearing Screening
	DOT Urine Drug Screen		Vision Screening
	DOT Breath Alcohol Testing		Other:

Authorization/tracking number for a urine drug screen, if applicable: _____

SERVICE(S) TO BE BILLED TO PATIENT (please mark all applicable services)

	DOT Physical/Bus Driver Physical		Non-DOT Urine Drug Screen, with Confirmation send off, if needed
	Pre Employment Physical (Non DOT)		Non-DOT Breath Alcohol
	Physical Capacity Profile Test		Collection Only – Urine Drug Screen
	Physical for Foster Care or Child Care Personnel		Hearing Screening
	DOT Urine Drug Screen		Vision Screening
	DOT Breath Alcohol Testing		Other:

WORKERS' COMPENSATION

Please attach the individual's physical requirements for the position he/she holds.

I authorize appropriate medical diagnosis and treatment for the individual noted on this document related to a Post-Accident Injury/Illness.

Date of Injury: _____

☐ Physical Demands/Job Description is attached.

Please mark one below:

☐ Complete a Post-Accident Urine Drug Screen.
☐ Complete a Post-Accident Breath Alcohol Screen.
☐ Do NOT complete Post-Accident screenings.

_____ _____
Employer Representative Signature Date

_____
Employer Representative Name (please print)

BILLING INFORMATION

☐ Bill directly to the Employer.

Employer Name: _____
Address: _____
Phone: _____ Fax: _____
Email: _____

☐ Submit claim to Workers' Compensation Insurance Carrier:

Insurance Company: _____
Policy/Account Number: _____
Address: _____
Phone: _____ Fax: _____

Claim Number (if known): _____

Thank you for choosing CHC/SEK for your Workplace Health Services.
Phone: 620-240-8985 Email: workplacehealth@chcsek.org

For CHC/SEK Use Only: Document attempt to contact employer for authorization.
Date of Attempted Contact: _____ Time: _____ Number: _____