# DOT Physical Authorization Form

**DIRECTIONS:**

Complete all Sections A - D entirely
( Only services marked on this form will be completed )

** All services require photo identification to be provided by employee at time of service.

This is authorization to provide medical services to:_____ DOB_____ SS#_____

*( Print Patient Name Above)*

## Section A: Employer Information

Employer Name:

Address:

Phone #

Fax #

### Third Party Administrator

Employer Name:

Address:

Phone #

Fax #

## Section B: Physical Examination

Donor will bring Physical Exam Form ❑ Yes ❑ No

❑ DOT Physical Exam

### These Additional Services MAY BE Required

Will Employer pay for the additional Services ?

❑ Yes ❑ No

❑ Spirometry – Pulmonary Function
❑ Audiometry
❑ Vision Test - Keystone
❑ Glucose Finger Stick
❑ Electrocardiogram (EKG)

## Section C: Urine Drug/Alcohol Tests

**Urine Drug Screens**

❑ Collection Only / Donor will bring COC

**Florida Drug Free Workplace**

❑ 5 Panel HRS
❑ 8 Panel HRS
❑ 10 Panel HRS

**DOT**

❑ DOT / NIDA

### Alcohol Testing
Lake Ella, Appleyard,
North & Mahan Locations Only

❑ DOT Breath Alcohol Test
❑ Non – DOT Breath Alcohol Test

**Additional Comments/ Notes:**

## Section D: Authorization Information

Print Name of Authorizer:

Fax or Mail results to:

Authorizer Signature:

Title:

**Billing: Please mark responsible billing party**

❑ Bill Employer
❑ Bill Third Party Administrator

Phone #

Date:

**For Patients First Use Only**: Phone Auth received by:

Date & Time