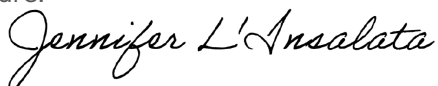


# employer authorization form



Employee Information			
Employee name:	DOB:	Last 4 SSN#:	
Employer Information			
Athena account #: 646609	eScreen account # (if applicable):		
Company name: 1199C / DCWG			
Company address: 100 Broad Street 9th Floor	City: Philadelphia	State: PA	Zip: 19110
Services scheduled date/time:	Services exp date/time:		
Name and title of person authorizing treatment (please print): Jennifer L'Insalata / Audie Murphy			
Signature: 	Phone: (412) 389-3024		
Preferred communication (please check all that apply): <input checked="" type="checkbox"/> phone <input checked="" type="checkbox"/> fax (secure) <input checked="" type="checkbox"/> e-mail (secure) <input type="checkbox"/> mail			
After-hours contact: (412)389-3024			
DER Information			
DER/Company contact for results and/or physician call: Jen L'Insalata / Audie Murphy			
DER email: jen@thetrainingfund.org	DER fax: (215)564-0450		
Bill Services To			
<input checked="" type="checkbox"/> Employer <input type="checkbox"/> Employee <input type="checkbox"/> TPA			
Billing Address/ TPA (only if different than above):			
Name:			
Address:	City:	State:	Zip:
Phone:	Ext:	Fax:	
Internal Use Only:			
<input type="checkbox"/> Employee did not arrive by the expiration date <input type="checkbox"/> Notified/called DER (no show only) <input type="checkbox"/> FOA Initials:			

# employer authorization form (con't)



## Employee Information

Employee name:

DOB:

## Step One (if applicable)

### Check the following:

- ☐ Using MedExpress Lab & MRO
- ☐ Using Company Provided Lab & MRO

## Step Two (UDS and BAT only)

### Reason for testing:

- ☒ Pre-Employment
- ☐ Post-Accident
- ☐ Random
- ☐ Reasonable Suspicion
- ☐ Return to Duty
- ☐ Follow up  
(DOT Return to Duty & Follow up Testing must be observed)

## Step Three

### Please select all services to be performed.

#### DOT Drug/Alcohol testing:

- ☐ DOT Urine Drug Screen (5-Panel only)
- ☐ DOT Breath Alcohol Test

#### Select the modality:

- ☐ FMSCA ☐ FTA ☐ FRA ☐ FAA ☐ PHMSA ☐ USCG

#### Non-DOT Drug/ Alcohol testing:

- ☐ Rapid Urine Drug Testing ☐ Send out Urine Drug Screen
- ☐ 5-Panel ☐ 10-Panel ☐ Custom Panel #

- ☐ Breath Alcohol Test
- ☐ Hair Collection
  - ☐ 5-Panel or ☐ 5-Panel w/exp Opiates
- ☐ Blood Alcohol (state specific)

#### Physical Examinations:

- ☐ DOT
  - ☐ New certification ☐ Re-certification
  - ☐ Interstate ☐ Intrastate
- ☐ School bus driver physical (if applicable)
- ☐ Standard Pre-Employment (non-DOT)
- ☐ eScreen ePhysical non-DOT look-alike
- ☒ Special Company Form  
(Requires approval- contact your Account Executive)
- ☐ Other

### Other Services:

- ☒ TB Skin Test
  - ☐ 1 Step or ☒ 2 Step
- ☐ QuantiFERON®-TB Gold Plus
- ☐ TD ☐ Tdap
- ☐ Hep B Vaccine
  - ☐ 1st ☐ 2nd ☐ 3rd
- ☐ Flu Shot
- ☐ Point of care lipid panel + glucose
- ☐ OSHA Audiogram
  - ☐ Baseline ☐ Annual ☐ Exit

### Labs:

- ☐ Blood Draw- Collection Only
- ☐ Hep C Titer ☐ Hep B Titer
- ☐ MMR Titer ☐ CMP ☐ CBC ☐ Other

### Additional Services: (Please call the Outcome Assurance Team to verify 304-985-6324)

- ☐ Resp. Fit Test (Quantitative)
- ☐ Pulmonary Function test
- ☐ Hep A Vaccine

## Special instructions:

**Medical Clearance Form****Personal Information (Please Print, Blue ink Only)**

<b>Last Name:</b>	<b>First Name:</b>	<b>M.I.:</b>	<b>Birthdate ( mm/dd/yyyy ):</b>
<b>Phone Number:</b>	<b>Cell Number:</b>	<b>e-mail:</b>	

**Two-Step Tuberculin Skin Test (Mantoux) only.****\*QuantIFERON Gold Test is NOT acceptable.****Step 1****Date Administered:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Date Read:** \_\_\_\_/\_\_\_\_/\_\_\_\_**PPD Determination:**

( ) Negative ( ) 0 MM  
 ( ) Positive

**Practitioner or Nurse Signature:** \_\_\_\_\_**Date:** \_\_\_\_\_**Step 2****Date Administered:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Date Read:** \_\_\_\_/\_\_\_\_/\_\_\_\_**PPD Determination:**

( ) Negative ( ) 0 MM  
 ( ) Positive

**Practitioner or Nurse Signature:** \_\_\_\_\_**Date:** \_\_\_\_\_**If Positive****Chest x-ray has been documented within the last two years?** **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_☐ Normal Chest x-ray☐ Abnormal Chest x-ray☐ Patient **was/is** treated with prophylactic medication. **Date treatment started:** \_\_\_\_/\_\_\_\_/\_\_\_\_**Treatment ordered:** \_\_\_\_\_**Physical Clearance**• **Any significant defect or disease?** ( ) Yes ( ) No• **The above named student is free of communicable diseases** ( ) Yes ( ) No☐ This person has been treated and there is no significant risk to others. ( ) Yes ( ) No☐ Long-term treatment or follow up is required and the employee/student could be a prohibitive employment risk. ( ) Yes ( ) No

Specify any precautions that must be taken in order for the employee/student to work with the residents in a Long Term Care Facility: \_\_\_\_\_

• Is the student able to lift at least 50 lbs on a frequent basis? ( ) Yes ( ) No

• Is the student able to stand and walk varied distances for at least eight (8) hours? ( ) Yes ( ) No

• Is the student able to push, pull and reach above his/her head, frequently? ( ) Yes ( ) No

\_\_\_\_\_  
Signature of Nurse Practitioner or Physician\_\_\_\_\_  
Date\_\_\_\_\_  
Print or Type Name**Office Stamp:****Address:**