employer authorization form

MedExpress

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: Jennifer L'Insalata	Phone: (412) 389-3024		
Preferred communication (please check all that apply): ✓ phone ☑ fax (secure) ☑ e-mail (secure) ☐ 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			
☑ Employer ☐ Employee ☐ TPA			
Billing Address/ TPA (only if different than above):			
Name:			
Address:	City:	State:	Zip:
Phone: Ext:	Fax:		
Internal Use Only:			
☐ Employee did not arrive by the expiration date ☐ Notified/called DER (no show only) ☐ FOA Initials:			

employer authorization form *(con't)*

MedExpress

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:

Health & Technology Training Institute #3950059

Medical Clearance Form

Personal Information (Please Print, Blue ink Only)

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

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:

_____
_____

Updated 10/2018 TK, 11/19 TK, 08/21TK