



AUTHORIZATION FOR TREATMENT

Company Name: _____

Employee/Applicant: _____

Injury: _____ Post Acc DS ____ Post Acc BAT ____

Date of Injury: _____

Services Authorized

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Physical Exam | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Return to Work Exam | |
| <input type="checkbox"/> DOT Physical – New Hire | |
| <input type="checkbox"/> DOT Physical - Recertification | |

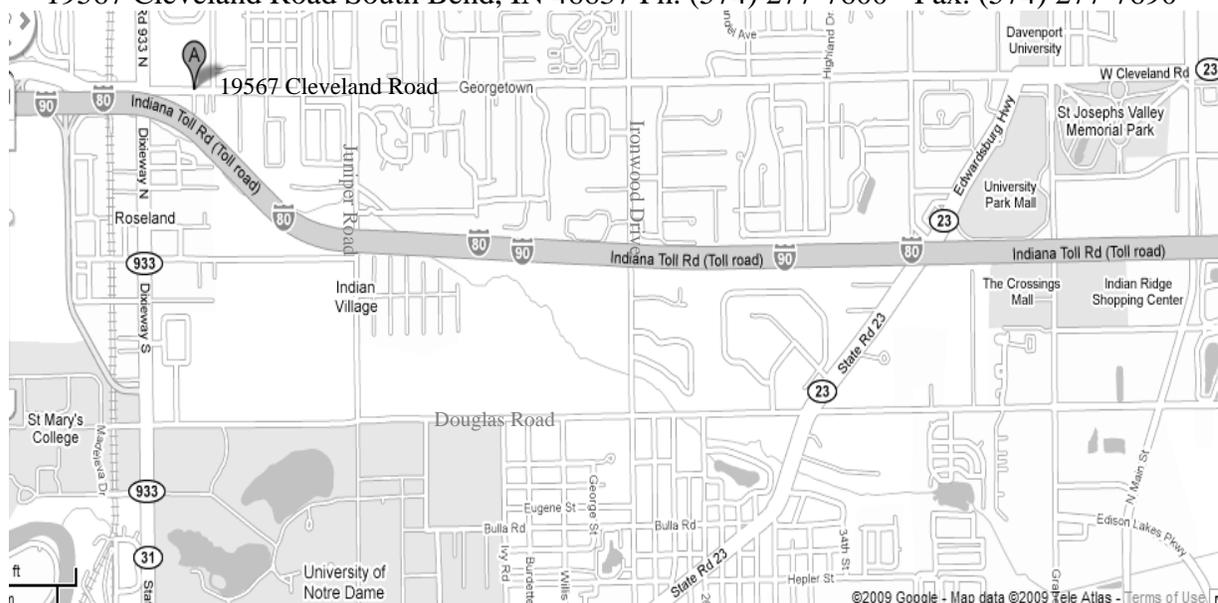
(Please check reason for the following tests to the right)

- | | |
|--|---|
| <input type="checkbox"/> Drug Screen (non DOT) | Reason for test(s) |
| <input type="checkbox"/> Breath Alcohol Test (non DOT) | <input type="checkbox"/> New Hire |
| <input type="checkbox"/> DOT Regulated Drug Screen | <input type="checkbox"/> Random |
| <input type="checkbox"/> DOT Regulated Breath Alcohol | <input type="checkbox"/> Post Accident |
| | <input type="checkbox"/> Reasonable Suspicion |
| | <input type="checkbox"/> Return to Duty |
| | <input type="checkbox"/> Follow-up |

Signature/Authorization below, is a guarantee of payment by the employer if, for any reason, the insurance company denies payment.

Authorized by: _____ Date: _____

19567 Cleveland Road South Bend, IN 46637 Ph. (574) 277-7600 · Fax. (574) 277-7690



Hours of operation: Monday – Friday 8am – 4:30pm