MEDNOW
Urgent Care + Walk-in Center

Employer Authorization for Occupational Services
PHOTO ID IS REQUIRED FOR ALL SERVICES

Patient Name:_____ **DOB:**_____ **SSN:**_____

Address: _____ **Phone:**_____

Reason for Test:

- ☐ Pre-Employment
- ☐ Post-Accident
- ☐ Random
- ☐ Recertification
- ☐ Return to Duty
- ☐ Reasonable Suspicion
- ☐ Periodic
- ☐ Follow-up

Substance Abuse Testing:

- ☐ Drug Screen (☐ DOT-Federal ☐NON-DOT)
- ☐ Drug Screen Collection (☐ DOT-Federal ☐NON-DOT)
- ☐ Hair Drug Screen (☐Our Form ☐ Collection/Employer CCF)
- ☐ 10 Panel Instant Drug Screen
- ☐ Breath Alcohol (☐ DOT-Federal ☐NON-DOT)

Physical Testing:

- ☐ Basic Physical
- ☐ DOT Physical
- ☐ Audiogram
- ☐ Pulmonary Function Test
- ☐ TB Test/PPD
- ☐ Chest X-Ray ☐ w/ Radiology Report
- ☐ EKG

Immunizations:

- ☐ Flu Vaccine
- ☐ Hepatitis B Vaccine
- ☐ MMR Vaccine
- ☐ Hepatitis B Titer
- ☐ Varicella Titer
- ☐ MMR Titer
- ☐ Tetanus Vaccine
- ☐ TDAP Vaccine

OTHER TESTING (if not listed):_____

**** Please be sure to send CCF/supplies with employee if we are collecting anything on employer custody and control form if we do not store your supplies on site. Thanks!**

Company Name:_____ **Authorized By:**_____

Phone: _____ **Date:**_____

Billing Information: ☐ Bill Employer ☐ Bill Third Party Administrator ☐ Employee Responsibility

Billing Address for Services: _____

How would to receive results: Email- _____ **Fax-** _____