



SETON MEDICAL CENTER HARKER HEIGHTS

MEDICAL AUTHORIZATION FORM

DATE: _____

Send the form with your employee or fax it to: (985) 632-1824

EMPLOYEE NAME: _____

JOB/PO# _____

COMPANY NAME: _____

PHONE# _____

COMPANY ADDRESS: _____

FAX# _____

CITY _____ STATE _____

ZIP CODE _____

<input type="checkbox"/> <u>WORK COMP INJURY</u> <input type="checkbox"/> Bill Company <input type="checkbox"/> Bill workers comp. insurance carrier: It is the responsibility of the company to call in a First Report of Injury (Form 1007) to your workers compensation insurance carrier. Please provide carrier info and claim number below. Workers Comp. Insurance Carrier Company: _____ Phone: _____ Address: _____ Adjustor: _____ City: _____ State: _____ Zip: _____ Please provide the claim number issued for this Workers Compensation Claim. Your assistance in providing the claim number for this injury will expedite the management of this injury and the processing of claims. Claim# _____	<input type="checkbox"/> <u>URINE DRUG SCREEN</u> <input type="checkbox"/> DOT (CDL) <input type="checkbox"/> Non-DOT <input type="checkbox"/> DOT Collection <input type="checkbox"/> Non-DOT Collection <input type="checkbox"/> Quick Screen <input type="checkbox"/> <u>ALCOHOL TESTING</u> <input type="checkbox"/> DOT <input type="checkbox"/> Non-DOT <input type="checkbox"/> Breath <input type="checkbox"/> Saliva <input type="checkbox"/> <u>REASON FOR TEST</u> <input type="checkbox"/> Post Accident <input type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> <u>PHYSICAL EXAMS</u> <input type="checkbox"/> Non-DOT
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AUTHORIZED BY: _____

(PRINT NAME)

TITLE: _____

(REQUIRED)