(Patient must present Authorization and Photo ID at the time of service.)

FORM C - Authorization for Examination or Treatment

Patient Name: ______________________________ Social Security Number: ______________________

Employer: ______________________________ Date of Birth: ______________________

Street Address: ______________________________ Location Number: ______________________

DOI Reported: ______________________________

Work Related

☐ Injury ☐ Illness ☐ Unknown

Substance Abuse Testing* (check all that apply)

☐ Rapid Drug Screen ☐ DOT Drug Screen

☐ Breath Alcohol Screen

Type of Substance Abuse Testing

☐ Preplacement ☐ Reasonable cause

☐ Post-accident ☐ Random

Physical Examination

☐ Preplacement ☐ Baseline ☐ Annual ☐ Exit

DOT Physical Examination

☐ Preplacement ☐ Recertification

CONDUCT: Drug & Alcohol Tests on ALL POST ACCIDENTS

☐ Evaluation Only Authorization: YES

SCHEDULE ALL PHYSICAL THERAPY WITH INDUSTRIAL ATHLETE PROS.

Billing *(REQUIRED)*

☐ **Employer to pay charges on Evaluation Only**

☐ **Physical Therapy Scheduled with IAP Only**

Authorized by: ______________________________ Title: ______________________
Please print

Phone: ______________________________ ______________________
Date

(Copies of this form are available at Temco Logistics)