Metairie
100 N. Labarre Rd, Suite C
Metairie, LA 70001
Ph. 504-827.1717
Fax. 504.827.1177
metairie@occmednow.com

IN + OUT URGENT CARE and Occupational Medicine

Covington
13130 Hwy 1085, suite 100
Covington, LA 70433
Ph. 985.809.8690
Fax. 985.809.8694
madisonville@occmednow.com

Employer Authorization for Examination and/or Treatment

Employee Name _____ Date _____

Date of Birth _____ Injury /Illness Specific Details
Date _____
Time _____

EMPLOYER INFORMATION (please print)

Company Name _____ Phone # _____

Address _____ Fax # _____

Person Authorizing Visit _____ Title _____

Signature of person authorizing visit X _____ Date _____

E-Mail _____ Direct # _____

REQUESTED SERVICES

☐ N/A	☐ DOT/CDL	☐ Return to Work Physical	☐ Annual Physical
☐ Pre-employment Physical	☐ TB Skin Test	☐ Audiometry	☐ Agilities Test
☐ PFT/Spirometry	☐ Respirartor Clearance	☐ OSHA Questionare	☐ Immunizations
☐ Mask Fit Test (Circle One)	☐ Other _____		
Full Half	_____		

Treatment for Injury -COMMENTS _____

TESTING (Please Specify Reason)

☐ DOT Urine Screen	☐ Non DOT 5 Panel	☐ Non DOT 10 Panel	☐ Rapid 12
(Specify agnecy)	☐ FTA	☐ FAA	☐ (Same Day)
☐ FMCSA	☐ PHSMA	☐ USCG	☐ FRA

COMMENTS: _____

DRUG AND ALCOHOL TESTING

☐ Pre-Employment	☐ Random	☐ Return to Work /Duty	☐ Follow up
☐ Reasonable Suspicion	☐ Post Accident	Must be observed	Must be observed

BILLING INFORMATION (please print)

☐ BILL TO COMPANY _____

Check box if this is being billed directly to company

Company Billing Address (if different from above)

_____

_____

Billing Contact person _____ Phone # _____

☐ BILL WORKERS COMP CARRIER

Check box if this is being billed directly to Worker's Comp

Worker's Comp Carrier _____ Phone # _____

Adjuster's Name _____ Claim # _____

Address _____

City State Zip Code

Other (please specify) _____ Light Duty YES NO

Circle one if this applies to you