AUTHORIZATION FORM

GENESIS OCCUPATIONAL HEALTH

- **2350 41st Street / Moline, IL 61265 / 309-281-2700 / Fax: 309-281-2709**
- **3319 Spring St #103 / Davenport, IA 52807 / 563-421-0660 / Fax: 563-421-0669**

Clinic Hours: Monday - Friday 8am - 5pm

(Patient Must Present Photo ID at Time of Service)

Company Name: ____ **Date:**__________________

Authorized By:____________________________________ **Phone:**_________________________

Employee Name: ____

Social Security #:___________________________ **Date of Birth:**___________________

Please mark ALL services that apply:

❖ Substance Abuse Testing:

____ DOT Drug Screen **(circle Dot Agency):** FMCSA, FTA, FAA, FRA, FHMSA ____Collection only

____Breath Alcohol **(circle):** DOT Non-DOT ____Hair Collection

____Rapid Drug Screen **(circle):** 5panel 9panel 10panel ____Non-DOT Drug Screen

❖ Reason for Testing:

____Pre-Employment ____Post Accident ____Random ____Return to Duty

____Reasonable Suspicion ____Follow-up ____Job Site ____Other

❖ Physical/Ancillary Testing:

____DOT Physical ____Non-DOT Physical ____Other____________________

____Functional Agility Testing (appointment only) ____PPD**(circle):** 1 step 2 step

❖ Injury Care:

Date of Injury:_________________ Post Accident Screening? **(circle):** NO YES-fill out upper portion of form

Body Part:_____________________________________

Claim Number:_________________________________

Who are we billing for services performed? (Circle): Company Insurance Third Party Admin

Name: Address:

Contact: Phone: