(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:______________________

Evaluation Only :______________________

Work Related

□ Injury □ Illness □ Unknown

DOI Reported:______________________

Substance Abuse Testing* (check all that apply)

□ Regulated drug screen □ Breath alcohol

□ Collection only □ Hair collect

□ Non-regulated drug screen □ Rapid drug screen

□ Other______________________

Type of Substance Abuse Testing

□ Preplacement □ Reasonable cause

□ Post-accident □ Random

□ Follow-up

****Special instructions/comments: All Physical Therapy is to be directed To Industrial Athlete Pros, LLC.****
Please send all PT back to the IAP.

Physical Examination

□ Preplacement □ Baseline □ Annual □ Exit

DOT Physical Examination

□ Preplacement □ Recertification

Special Examination

□ Asbestos □ Respirator □ Audiogram

□ Human Performance Evaluation*

□ HAZMAT □ Medical Surveillance

□ Other______________________

Billing (check if applicable)

□ **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)