ACCESS MEDICAL
ASSOCIATES

AUTHORIZATION FOR MEDICAL SERVICES

COMPANY NAME: _____ PHONE_____

PATIENT'S NAME: _____ DATE: _____

I hereby certify that the above named company is requesting and authorizing medical testing and or treatment for the above employee or prospective employee, and is accepting responsibility for payment of services rendered unless services are covered by worker's compensation or patient's private insurance carrier. (Not required if employee or prospective employee is responsible for payment of bill at time of service).

AUTHORIZED BY: _____ _____
Please Print Name **Signature**

DESCRIPTION OF INJURY/COMMENTS: _____

SPECIAL INSTRUCTIONS_____

SERVICES REQUESTED:

____ PHYSICAL EXAM: ___ CDL ___ Pre-Employment ___ Post-Accident ___ HAZMAT

___ Crane Operators ___ Return to Work (Fit-for-Duty) ___ Respirator Clearance

___ Other: _____

____ URINE DRUG SCREEN ____ Point-of-Care Testing (In-House Dip)

___ DOT Chain-of-Custody ___ Non-DOT Chain-of-Custody ___ 5 Panel ___ 10 Panel

Reason for Test:

___ Pre-Employment ___ Random ___ Reasonable Suspicion/Cause ___ Post Accident

___ Other: _____

____ HAIR DRUG SCREEN

____ SALIVA ALCOHOL TESTING

____ FUNCTIONAL CAPACITY EXAM (FCE) - APPOINTMENT REQUIRED

____ WORKER'S COMPENSATION: → **Is light duty available?** ____Yes ____No (check one)

____ OTHER: _____

EMPLOYEE RELEASE (Employee must sign below for service to be rendered)

I HEREBY AUTHORIZE ACCESS MEDICAL ASSOCIATES TO RELEASE WORK-RELATED INFORMATION PERTAINING TO THIS VISIT TO MY EMPLOYER OR PROSPECTIVE EMPLOYER, TO THE EXTENT NECESSARY FOR COMPLIANCE WITH THE COMPANY'S EMPLOYEE HEALTH, OCCUPATIONAL PROGRAM, OR ROUTINE HIRING POLICY.

_____ _____

Employee or prospective employee name Employee or prospective employee signature

Branchburg Commons, 3322 Route 22 West, Branchburg, NJ 08876 (908) 704-0100 Fax (908) 704-0090

Office@AccessMedicalAssoc.com http://AccessMedicalAssoc.com