BARNABAS HEALTH
Corporate Care

Authorization for Treatment

Patient Name: _____

Employer: _____

Employer Contact: _____

Employer Phone: _____

Employer Fax or email: _____

☐ Injury **
Date of Injury _____

☐ Pre-placement Physical
and: _____

☐ Drug Screen: __ Rapid __ Collection Only ☐ Breath Alcohol

Please check reason for substance testing:

__ Pre-placement __ Random __ Post-accident __ Reasonable cause

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☐ DOT Physical: __ Initial __ Recertification

☐ Vaccination: _____

☐ Human Performance Evaluation ☐ Spirometry

☐ Audiogram ☐ EKG

☐ Respirator FIT test

Special instructions/comments:_____
** Please list description of injury

(All patients must bring valid PHOTO ID to the appointment)