www.mylocalurgentcare.net

Authorization for Physical Drug Screen

Date: _____

Patient Name: _____

Patient's DOB: _____

Employer: _____

Employer's address: _____

_____

Employer's phone number: _____

Fax or Email Drug Screen Results to: _____

Check Services Requested:

Drug Screen required? ☐ **YES** ☐ **NO** ☐ **DOT** ☐ **NON-DOT**

Reason for Screen: ☐ Pre-Employment ☐ Random ☐ Post-Accident ☐ Other: _____

Physical ☐ **YES** ☐ **NO** ☐ **DOT** ☐ **NON-DOT**

_____ _____

Authorizing name (printed) Authorizing signature