



Authorization for Services

Please fax completed form to the Occupational Health location where the Patient will be seen (Patient must Present Photo ID at Time of Service)

Employee/Applicant Name: Employer:

Employer Address: Department:

Employer Phone#:

Physical Examinations:

- Pre-Employment Annual Exit DOT Other
Respirator Exams Hazmat Audiogram

Drug and Alcohol Surveillance:

- 10 Panel Drug DOT Drug Drug Screen Instant Breath Alcohol Other
Screen with MRO Screen with MRO Collection Only Drug Screen

Reason for Drug Screening:

- Pre-Employment Annual Random Post Accident Reasonable Suspicion Other

For Services above Bill:

- Company Self Pay at time of Exam

Work Related Injury Bill: Company Carrier Name:

Workers Compensation Insurance Carrier and Address:

Claim Number:

Date of Injury:

Explanation of Injury

Special Instructions or Comments:

Authorized By: Title:

Signature: Date:

- Eatontown Neptune Lakewood Manalapan Holmdel Toms River
2-12 Corbett Way 2441 Hwy 33 150 Airport Road 195 Route 9 South 100 Commons Way 1430 Hooper Ave
Suite 101 Suite A Suite 100 Suite 213 Suite 160 Suite 200B
Eatontown, NJ 07724 Neptune, NJ 07753 Lakewood, NJ 08701 Manalapan, NJ 07726 Holmdel NJ 07733 Toms River, NJ 08753
P#732-263-7950 P#732-776-4251 P#732-942-9550 P#732-450-2745 P#732-450-2930 P#732-557-0700
F#732-263-7946 F#732-776-4210 F#732-942-9554 F#732-405-2746 F#732-450-2931 F#732-557-9159