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 Screen with MRO ☐ DOT Drug Screen with MRO ☐ Drug Screen Collection Only ☐ Instant Drug Screen ☐ Breath Alcohol ☐ Other______ _____________

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
2-12 Corbett Way
Suite 101
Eatontown, NJ 07724
P#732-263-7950
F#732-263-7946

☐ Neptune
2441 Hwy 33
Suite A
Neptune, NJ 07753
P#732-776-4251
F#732-776-4210

☐ Lakewood
150 Airport Road
Suite 100
Lakewood, NJ 08701
P#732-942-9550
F#732-942-9554

☐ Manalapan
195 Route 9 South
Suite 213
Manalapan, NJ 07726
P#732-450-2745
F#732-405-2746

☐ Holmdel
100 Commons Way
Suite 160
Holmdel NJ 07733
P#732-450-2930
F#732-450-2931

☐ Toms River
1430 Hooper Ave
Suite 200B
Toms River, NJ 08753
P#732-557-0700
F#732-557-9159