



Occupational Treatment Authorization

Employee Name: _____

Job Title: _____ Social Security #: _____ DOB: _____

Company Name: _____ Employer ID # _____

Address: _____ Store # _____

Phone: _____ Email : _____

Person Authorizing (Please Print): _____ Title: _____

Authorization Expires on Date: _____ Time: _____

New Company Account with Texas MedClinic
 Existing Company Account with Texas MedClinic

PHYSICALS

- Post Offer Physical***
Job Description On File Job Description Provided
- DOT Physical**
- Respirator Physical**
- Hazardous Waste Physical**
- Asbestos Physical** Initial Periodic
- Silica Dust Exams**** (Includes: TB test, Chest X-Ray, Spirometry & Physical)

DRUG/ALCOHOL TESTING

Reason for Testing

- | | |
|----------------------|---------------------------|
| Pre-Employment | For Cause |
| Post Accident | Follow -Up (DOT Only) |
| Random | Return to Duty (DOT Only) |
| Reasonable Suspicion | Other: _____ |

ANCILLARY

- TB test**
X-ray authorized for TB Test if needed (Physician Evaluation Required)
- T-Spot Blood Test**
- Audiogram**
- Spirometry**
- Respirator Fit Test*****
- Functional Ability Test** (If authorized on company profile)
- Vision Test**

NON-DOT DRUG TESTING	DOT DRUG TESTING	
5 Panel	DOT Drug Test	
10 Panel		
Rapid 5 Panel *	DOT Testing Agency	DOT Testing Authority
Rapid 10 Panel *	FMCSA FTA	DOT
Hair Drug Test	FAA PHMSA	HHS
	FRA USCG	NRC
	BREATH ALCOHOL TESTING	
	Non-DOT	
	DOT	

IMMUNIZATIONS

- Hepatitis A MMR
- Hepatitis B Varicella
- Td Flu Shot
- Tdap Other: _____

TITERS

- Hepatitis A
- Hepatitis B
- Varicella
- MMR
- Other: _____

Consortium/Third Party Administrator

- DISA Onsite Services
- CMI FleetScreen
- HireRight Other: _____

Chain of Custody Form

- Electronic (Form Fox)
- Employee will hand carry
- Forms on file at clinic

COMMENTS/ADDITIONAL SERVICES:

*Employee will be evaluated to determine if he/she can perform the functions of the job. A written or verbal job description will be used at Physician's discretion.
** Silica Exams Only - Services will take more than one day to complete and are only performed at selected locations
***Must bring mask & performed at selected locations only

Office Use Only: TA completed by Employer TA completed by Clinic Staff Staff Name: _____ Date: _____ Time: _____