Texas MedClinic®

Check-In ONLINE Save Time!

Employer Paid Service (EPS) Treatment Authorization

Employee /Candidate Name: _____ **Job Title:** _____

Cell Phone # _____ **Social Security #:** ___XXX-XX-_____**DOB:**_____

Company Name: _____

Address: _____ **Dept / Location:** _____

Phone: _____ **Email :** _____

Person Authorizing (Please Print): _____ **Title:** _____

Authorization Expires on Date:_____ **Time:**_____

Clinic Location:_____

DRUG & ALCOHOL TESTING

Reason for Testing

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

Drug Test with MRO Services

- ☐ 5 Panel
- ☐ Rapid 5 Panel
- ☐ Hair Drug Test
- ☐ 10 Panel
- ☐ Rapid 10 Panel
- ☐ DOT Drug Test

Breath Alcohol Testing

- ☐ DOT
- ☐ Non-DOT

Consortium / TPA - Specimen Collection Only

- ☐ Non-DOT
- ☐ DOT
- ☐ DISA
- ☐ Onsight Services
- ☐ Form Fox
- ☐ Hire Right
- ☐ FleetScreen
- ☐ Other: _____

PHYSICAL

- ☐ **Post Offer Physical***
- ◯ Job description on file at clinic
- ◯ Job description hand carried by employee

REGULATED PHYSICALS

- ☐ **DOT Physical**
- ☐ **Respirator Physical**
- ☐ **Hazardous Waste Physical**
- ☐ **Asbestos Physical**
- ☐ **Silica Dust Exams****

ANCILLARY

- ☐ **TB Skin test**
- ◯ X-ray authorized for TB Test

(Provider Evaluation Required)

- ☐ **TB IGRA Blood Test**
- ☐ **Audiogram**
- ☐ **Respirator Fit Test *****
- ☐ **Vision Test**
- ☐ **Pulmonary Function Test**
- ☐ **Functional Capacity Screening**

IMMUNIZATIONS

- ☐ **Hepatitis A**
- ☐ **Hepatitis B**
- ☐ **Flu shot**
- ☐ **TDap**
- ☐ **MMR**
- ☐ **Varicella**
- ☐ **Td**
- ☐ **Other**_____

BLOOD TITERS

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

** 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 providers discretion.*
*** Silica Exams Only - Services will take more than one day to complete and are only performed at selected locations*
**** Must bring mask for Respirator Fit testing.*

COMMENTS/ADDITIONAL SERVICES:

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