



6900 E. 47th AVENUE DR. SUITE 100  
 DENVER, CO 80216  
 (303) 333-4411 Phone  
 (303) 333-8719 Fax  
 www.workcompdoc.net

## Treatment Authorization

Date \_\_\_\_\_  
 Company \_\_\_\_\_  
 Employee Name \_\_\_\_\_  
 Supervisor Name \_\_\_\_\_  
 Supervisor Phone \_\_\_\_\_  
 Date of Injury \_\_\_\_\_ Time of Injury \_\_\_\_\_

### Check all That Apply:

- Medical Treatment:**  On the Job Injury  
**Physical Examinations:**  DOT New Hire  
 DOT Re-Certification  Return to Work Evaluation  
 Respiratory Physical  Other/Specify \_\_\_\_\_

- Drug Screens:**  DOT  Non-DOT Lab Based  
 Urine  Saliva  Hair **OR**  Urine Stat-Test

- Breath Alcohol Test:**  DOT  Non-DOT

### Reason for Drug and/or Alcohol Testing:

- Pre-Employment  Post Accident  Random  
 Reasonable Suspicion  **DOT** Return-to-Duty  **DOT** Follow-Up

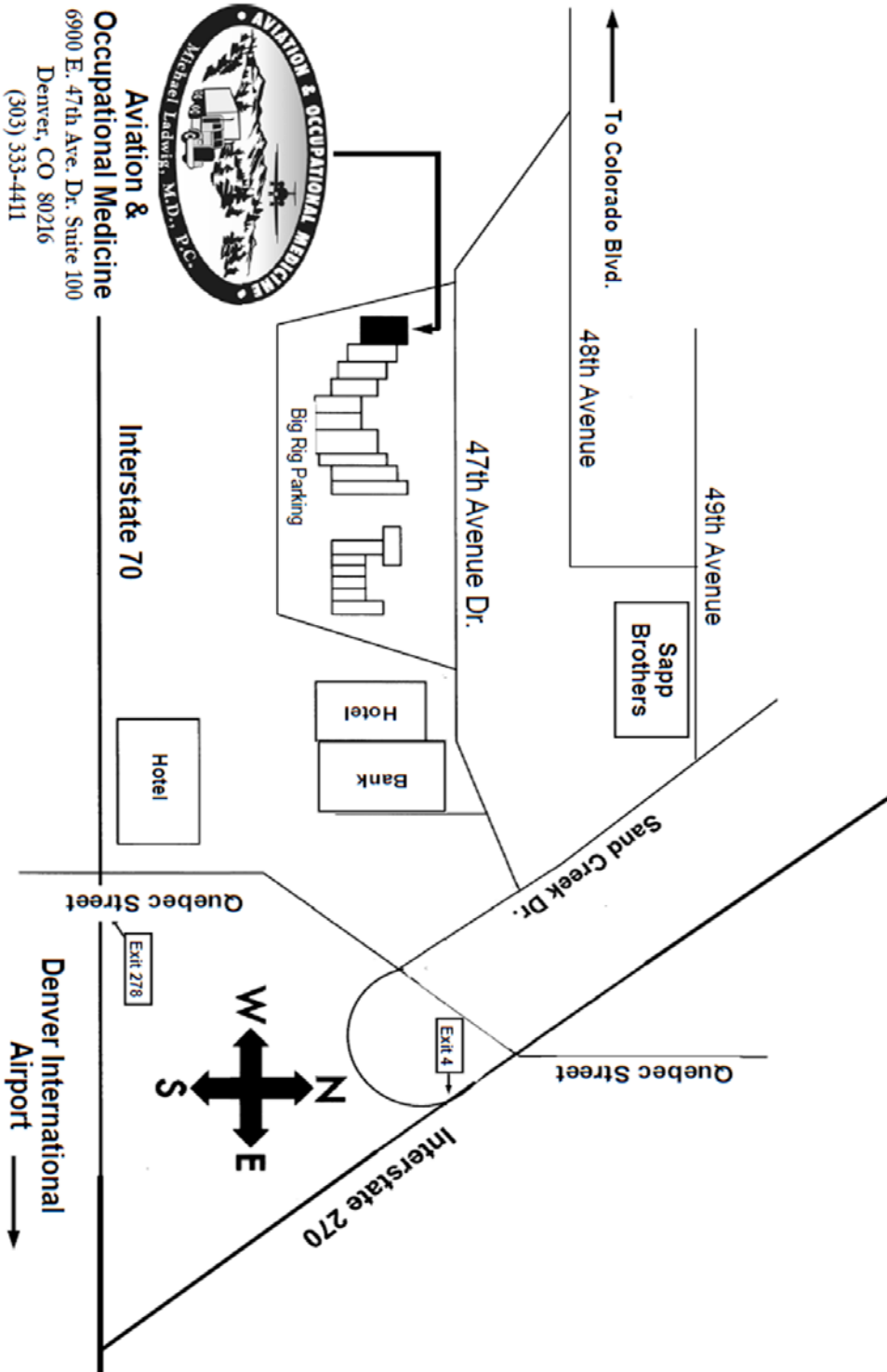
Add'l Info: \_\_\_\_\_

Type of Injury (describe complaint): \_\_\_\_\_

Treatment Authorized By: \_\_\_\_\_

MEDICAL OFFICE USE ONLY  
 Verbal Authorization Obtained From: \_\_\_\_\_  
 Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SEE MAP ON REVERSE



Aviation & Occupational Medicine  
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 Denver, CO 80216  
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