



3800 Jackson Street
 Alexandria, LA 71301
 Phone: (318) 767-9015 Fax: (318) 767-9983

AUTHORIZATION FORM

Send the form with your employee or **fax** it to: **(318) 767-9983** **DATE:** _____

EMPLOYEE NAME: _____ **DATE OF INJURY:** _____

COMPANY NAME: _____ **PHONE:** _____

COMPANY ADDRESS: _____ **FAX:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **PO/JOB #:** _____

SUPERVISORS NAME: _____ **PHONE:** _____

SEND REPORTS VIA: **FAX** _____ **E-MAIL** _____

MAIL _____ **OTHER** _____

****SERVICES RENDERED ON CHECKED ITEMS ONLY****

<p><u>WORK COMP INJURY</u></p> <p><input type="checkbox"/> Bill Above Named Company</p> <p><input type="checkbox"/> Bill Workers Comp Insurance Carrier: It is the responsibility of the company to call in a First Report of Injury (Form IA-1) to your workers' compensation insurance carrier. Please provide carrier info and claim number below.</p> <p style="margin-left: 40px;">Workers Comp Insurance Carrier</p> <p style="margin-left: 40px;">Company: _____</p> <p style="margin-left: 40px;">Phone: _____</p> <p style="margin-left: 40px;">Address: _____</p> <p style="margin-left: 40px;">Adjustor: _____</p> <p style="margin-left: 40px;">City: _____</p> <p style="margin-left: 40px;">State: _____ Zip: _____</p> <p style="margin-left: 40px;">Claim No.: _____</p> <p>Your assistance in providing the claim number for this injury will expedite the management of this injury and the processing of claims.</p>	<p><u>DRUG SCREEN</u></p> <p><input type="checkbox"/> DOT</p> <p><input type="checkbox"/> Non-DOT</p> <p><input type="checkbox"/> DOT Collection</p> <p><input type="checkbox"/> Non-DOT Collection</p> <p><input type="checkbox"/> Quick Screen</p> <p><input type="checkbox"/> Hair</p> <p><input type="checkbox"/> Other _____</p> <p><u>ALCOHOL TESTING</u></p> <p><input type="checkbox"/> DOT</p> <p><input type="checkbox"/> Non-DOT</p> <p><input type="checkbox"/> Breath</p> <p><input type="checkbox"/> Saliva</p> <p><input type="checkbox"/> Other _____</p> <p><u>REASON FOR TEST</u></p> <p><input type="checkbox"/> Post Accident</p> <p><input type="checkbox"/> Pre-employment</p> <p><input type="checkbox"/> Random</p> <p><input type="checkbox"/> Other _____</p> <p><u>PHYSICAL EXAMS</u></p> <p><input type="checkbox"/> Non-DOT</p> <p><input type="checkbox"/> DOT</p> <p><u>OTHER</u></p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p>
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AUTHORIZED BY: _____ **TITLE:** _____

(PRINT NAME) (REQUIRED)