COLORADO OCCUPATIONAL MEDICINE PHYSICIANS, P.C.
AUTHORIZATION FOR EVALUATION OR TREATMENT

DATE: _____ / _____ / _____

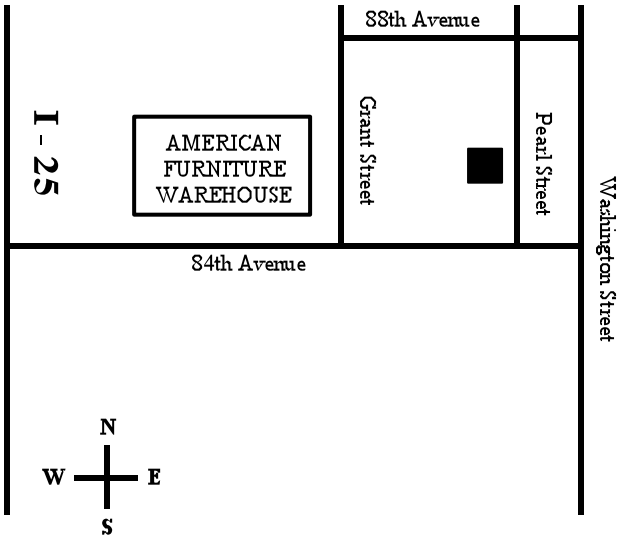
COMPANY: _____ PHONE: (_____) _____ - _____

EMPLOYEE NAME: _____

AUTHORIZED BY: _____

SIGNATURE: _____

8515 Pearl Street – Suite 300
Thornton, Colorado 80229
Phone: (303) 853-8989
Fax: (303) 289-7825



☐ **DRUG AND ALCOHOL TESTING**	☐ **EXAMINATION**	☐ **WORK RELATED ILLNESS OR INJURY**
☐ DOT ☐ NON-DOT	☐ Post-Offer	Date of Incident: _____ / _____ / _____
☐ Post-Offer	☐ Health Surveillance	Description:
☐ Post-Accident	☐ Return to Work / Fitness	_____
☐ Reasonable Cause	☐ DOT	_____
☐ Random	☐ HAZMAT	_____
☐ Rapid Drug Screen	☐ Respirator	_____
☐ Breath Alcohol	☐ Asbestos	_____
☐ Drug Screen Collection Only	☐ Other: _____	_____

---------- ***FOR COMP INTERNAL USE ONLY*** ----------

Verbal Authorization from: _____

Staff Signature: _____