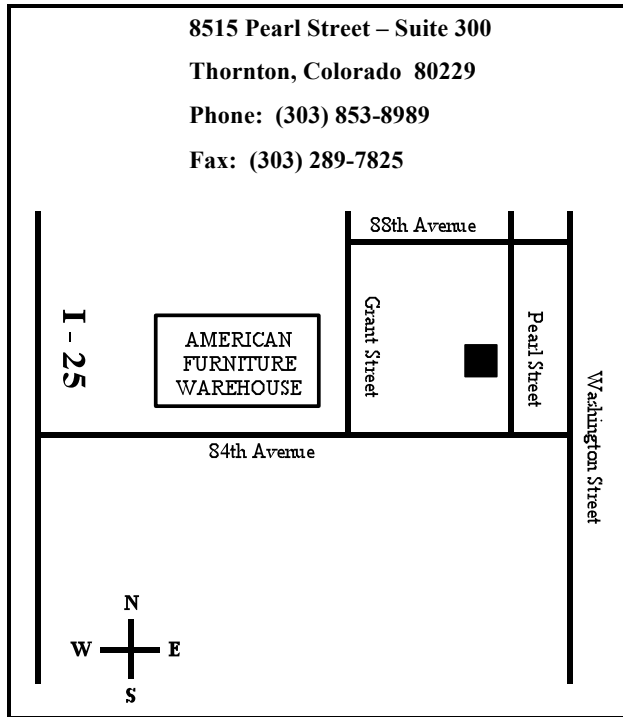


COLORADO OCCUPATIONAL MEDICINE PHYSICIANS, P.C.
AUTHORIZATION FOR EVALUATION OR TREATMENT

DATE: _____ / _____ / _____
 COMPANY: _____ PHONE: (_____) _____ - _____
 EMPLOYEE NAME: _____
 AUTHORIZED BY: _____
 SIGNATURE: _____



<input type="checkbox"/> <u>DRUG AND ALCOHOL TESTING</u> <input type="checkbox"/> DOT <input type="checkbox"/> NON-DOT <input type="checkbox"/> Post-Offer <input type="checkbox"/> Post-Accident <input type="checkbox"/> Reasonable Cause <input type="checkbox"/> Random <input type="checkbox"/> Rapid Drug Screen <input type="checkbox"/> Breath Alcohol <input type="checkbox"/> Drug Screen Collection Only	<input type="checkbox"/> <u>EXAMINATION</u> <input type="checkbox"/> Post-Offer <input type="checkbox"/> Health Surveillance <input type="checkbox"/> Return to Work / Fitness <input type="checkbox"/> DOT <input type="checkbox"/> HAZMAT <input type="checkbox"/> Respirator <input type="checkbox"/> Asbestos <input type="checkbox"/> Other: _____	<input type="checkbox"/> <u>WORK RELATED ILLNESS OR INJURY</u> Date of Incident: _____ / _____ / _____ Description: _____ _____ _____ _____
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----- **FOR COMP INTERNAL USE ONLY** -----

Verbal Authorization from: _____

Staff Signature: _____