State of Maryland

Authorization for Examination or Treatment

(Employee/Applicant Must Present Photo ID at Time of Service)

Agency:_______________________________ **Today's Date**:__________________________

(List Agency or Sub-Agency to Receive Invoice) **Appointment Date/Time/Location** (if applicable):

____

Agency Location:________________________**Authorized By**:___________________________

Agency Phone No.:______________________**Agency Fax No**:____________________________

Employee:_____________________________**Employee Date of Birth**:_____________________

Please check all that apply:

☐ **Work Injury/Illness** Date of Injury_______________ **Claim# (if available)** _____________

Physical Examination

☐ Pre-placement ☐ Pre-placement w/ Ergonomic Assessment ☐ DOT– Regulated (Recert ONLY)

☐ Fitness for Duty/Ability to Work ☐ Medical Surveillance ☐ FAA - MDOT

☐ Initial Workability ☐ Follow-up Workability ☐Other: ____________________________

Substance Abuse Testing

☐ DOT - Regulated Drug Test ☐ Non-regulated Drug Test

☐ DOT – Regulated Alcohol (Breath) ☐ Non-regulated Alcohol Test

☐ Other:________________________ ☐ Direct Observation Required

Reason for Substance Abuse Testing

☐ Pre-employment ☐ Reasonable Suspicion ☐ Post-accident ☐ Random

☐ Follow-up ☐ Return to Duty ☐ Other ____________________________

Psychological Services

*****Please Provide Employee/Applicant Phone # and Zip Code -AND- DAC's Email Address*****

☐ Psychological Testing (Psych Eval) ☐ SAP ☐ Critical Incident Management

Other Services

☐ Respirator Fit Test ☐ Audiogram ☐ PPD ☐ Pulmonary Function Test ☐ EKG

☐ Chest X-ray ☐ Vaccinations:________________________ ☐ Chromium

☐ Other:____

Special instructions/comments ____

____