



State of Maryland

Authorization for Examination or Treatment

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

Agency: _____

(List Agency or Sub-Agency to Receive Invoice)

Today's Date: _____

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 USDOT Medical Exam

Fitness for Duty/Ability to Work Medical Surveillance

Initial Workability Follow-up Workability Other: _____

Substance Abuse Testing (must choose)

DOT (FMCSA) Regulated Drug Test DOT Regulated Breath Alcohol Test

Non-Regulated Drug Test – 6 Panel Non-Regulated Breath Alcohol Test

Non-Regulated Police, Sworn Officer, Public Safety Drug Test – 7 Panel

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 _____