

MEDICAL AUTHORIZATION

Name _____ Date _____ Phone _____
 Company _____ Referred by _____

PLEASE NOTE: As a representative of the company indicated above, I hereby authorize Stillwater Medical Group to examine and treat, if necessary, the individual bearing this form. The company agrees to accept financial responsibility for this service.

REASON FOR VISIT

INJURY / ILLNESS:

- Work-related Non work-related Please determine

*The following services must be provided at the Curve Crest Specialty Clinic.
 After-hours drug and alcohol testing provided at Lakeview Hospital Emergency Room.
 A picture identification must be presented for drug and alcohol testing.*

URINE DRUG TESTING:

- Type: Pre-employment
 Return to duty

DOT

- Random
 Follow-up

Non-DOT

- Post Accident
 Reasonable Suspicion

ALCOHOL TESTING:

- Type: Pre-employment
 Return to duty

DOT - Breath

- Random
 Follow-up

Non-DOT - Blood

- Post Accident
 Reasonable Suspicion

PREPLACEMENT EXAM:

Job Position: _____ Other: _____

DOT / ICC EXAM:

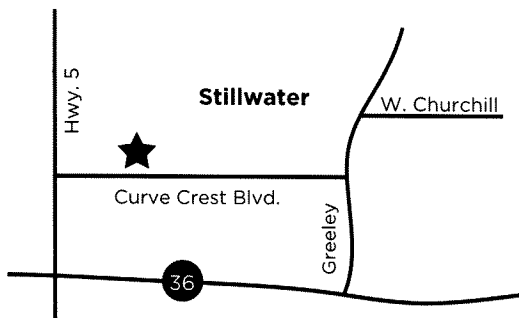
- Recertification: Preplacement DOT

EVALUATION EXAM:

- Fitness for Duty: Return to Work Impairment

MEDICAL SURVEILLANCE:

Type: _____ Other: _____



WorkWell Clinic Hours:

Mon - Fri 8:00 am - 5:00 pm
 Appointments recommended.
 Walk-ins if time available.

Appointment Telephone Numbers:

Drug Screens & Exams (651) 275-3330
 Work Injuries (651) 439-1234

Time In: _____

Time Out: _____