Service Authorization

**Please fill out this form entirely.*

_____ authorizes High Desert Clinic to perform the procedure(s) checked below.
Company Name

[ ] Injury Treatment **[ ] DOT Physical [ ] CDL Physical**

[ ] Urine Specimen collection for the drug screen using: **DOT or NON-DOT** kits & forms (using DOT guidelines)
Circle One

[ ] Evidential Breath Alcohol Test using: **DOT or NON-DOT** forms (using DOT guidelines)
Circle One

Employee Name: _____

SSN or Employee Number: _____

Authorized By: _____
DER/Supervisor Date Time Sent

Additional Instructions

If Federal; Testing Authority:
[ ] HHS
[ ] MRC
[ ] DOT- specify agency; please circle one of the following:

FMCSA FAA FRA FTA PHMSA USCG

Please indicate on the reason for the test:

[ ] Pre-employment
[ ] Random
[ ] Reasonable suspicion/cause
[ ] Post-accident
[ ] Return to duty
[ ] Follow up

Breath Alcohol results, suspected adulteration of the urine specimen, the need to monitor or observe the collection, or any difficulties will be reported immediately by phone to employer's DER at:

DER Name: _____

Phone Number: _____

Alternate DER: _____

Phone Number: _____

Results reported via _____

*****PLEASE PROVIDE BILLING INSTRUCTIONS**