CAREonsite by Tang+Company®

○ 1805 Arnold Drive, Martinez, CA 94553
Tel: (925) 335-5050 • Fax: (925) 335-5051 • Email: martinezclinic@careonsite.com
○ 20300 S. Vermont Ave, Torrance, CA 90502
Tel: (562) 437-0831• Fax: (562) 624-2725 • Email: torranceclinic@careonsite.com

Employer Authorization For Clinic Services

***** This form and valid photo ID are required for medical, surveillance, and drug & alcohol services *****

DEMOGRAPHIC INFORMATION:

*Requested Date of Service: _____ *Employee Name: _____ *Job Title: _____
First ***Middle*** ***Last***

Job #: _____ PO#: _____ *Refinery name, if applicable: _____

*Company Name: _____ *Dept/Work Location: _____

Site Address: _____

*Authorized by: _____ *Signature: _____
Print Name ***Signature confirms company's responsibility for payment of services***

*Employer Contact Phone #: _____ Employer Email: _____

DRUG AND ALCOHOL TESTING:

DOT: ❑ **Drug Testing** (Mode) _____ ❑ **Alcohol/Breathalyzer** (Mode) _____

NON-DOT: • Drug Testing ❑ Hair ❑ Oral Fluid ❑ Urine Lab/Send-out ❑ Quick Test (POCT) • ❑ **Alcohol/Breathalyzer**

❑ Pre-Access ❑ Pre-Employment ❑ Post-Accident ❑ Random ❑ Return-to-Duty ❑ Follow-Up ❑ Reasonable Suspicion/Cause

❑ eCCF (e.g., FormFox) *Consortium:_____ (*please fill in consortium that test is needed for, if applicable)*

PHYSICALS AND MEDICAL SURVEILLANCE:

❑ Annual Surveillance ❑ Post Offer/Pre-Employment ❑ DOT/CDL Driver ❑ Fit for Duty

❑ Return-to-work *(Patient needs to bring clearance from their primary physician)* ❑ Other Physical(s) (*specify*)_____

❑ Audiogram Test Only ❑ Audiogram/Hearing Conservation with Baseline ❑ Spirometry Test

❑ Respiratory Clearance +Exam *(Pt. to be seen by provider)* ❑ Respiratory Clearance – No Exam *(Clearance only)*

❑ Respiratory Fit Test *(mask size(s), make(s), & model(s) required)* _____

❑ Other Services: _____ *(e.g., Immunizations, bloodwork, x-ray, etc.)*

INJURY:

Is the Injury work-related? ❑ Yes ❑ No ❑ Unknown Date of Injury (DOI): _____ ❑ Estimated Date
mm/dd/yyyy

Describe Injury: _____

Work Location Where Injury Occurred: *(e.g., refinery or construction site name)*: _____

***Payor (one choice required):** ❑ Employer • ❑ Employer's Insurance • ❑ Employee • ❑ OCIP *(indicate site owner)* _____

Claim #: _____ Comments: _____

Please DO NOT place services in the comments section above.

** indicates required field*