2400 Ryan Street
Lake Charles, LA 70601
Phone: (337) 990-8001 Fax: (337) 433-3455

AUTHORIZATION FORM

Send the form with your employee or **fax** it to: **(337) 433-3455** **DATE:** ____________________

EMPLOYEE NAME: ____________________ **DATE OF INJURY:** ____________________

COMPANY NAME: ____________________ **PHONE:** ____________________

COMPANY ADDRESS: ____________________ **FAX:** ____________________

CITY: ____________________ **STATE:** __________ **ZIP:** __________ **PO/JOB #:** ____________________

SUPERVISORS NAME: ____________________ **PHONE:** ____________________

SEND REPORTS VIA: □ **FAX** ____________________ □ **E-MAIL** ____________________

□ **MAIL** ____________________ □ **OTHER** ____________________

******SERVICES RENDERED ON CHECKED ITEMS ONLY******

WORK COMP INJURY

☐ Bill Above Named Company

☐ Bill **Workers Comp Insurance Carrier**: It is the responsibility of the company to call in a First Report of Injury (Form IA-1) to your workers' compensation insurance carrier. Please provide carrier info and claim number below.

Workers Comp Insurance Carrier
Company: ____________________
Phone: ____________________
Address: ____________________
Adjustor: ____________________
City: ____________________
State: ____________ Zip: __________
Claim No.: ____________________

Your assistance in providing the claim number for this injury will expedite the management of this injury and the processing of claims.

DRUG SCREEN
☐ DOT
☐ Non-DOT
☐ DOT Collection
☐ Non-DOT Collection
☐ Quick Screen
☐ Hair
☐ Other ____________

ALCOHOL TESTING
☐ DOT
☐ Non-DOT
☐ Breath
☐ Saliva
☐ Other ____________

REASON FOR TEST
☐ Post Accident
☐ Pre-employment
☐ Random
☐ Other ____________

PHYSICAL EXAMS
☐ Non-DOT
☐ DOT

OTHER
☐ ____________
☐ ____________

AUTHORIZED BY: ____________________ (PRINT NAME) **TITLE:** ____________________ (REQUIRED)