ACADIANA CENTER

2501 W. Pinhook Rd. ♦ Lafayette, LA 70508
Phone 337-269-0136 ♦ Fax 337-233-8525

# *Authorization Form for Services*

Employee Name: _____ PO #: _____

Company: _____

Company Contact: _____ Phone number: _____

**(Check all of the services you are requesting)**

☐ Workers Compensation Injury, Evaluate and Treat

☐ Orthopedic Pre-Employment Evaluation

☐ Return-to-Work Evaluation

☐ Fit-for-Duty Evaluation

☐ Pre-Employment Physical

☐ DOT Physical – **Check One:** ☐ Pre-employment ☐ Re-certification

☐ Specialty Physicals: **Check One:** ___ Coast Guard ___ Crane ___ Oil & Gas UK ___ SAUDI

☐ DISA Drug Screen: **Check One:** ___ DOT ___ Non-DOT

☐ DOT Drug Screen: **Check One** for ***each group***:

**Group One:** ___ Pre-employment ___ Random ___ Post Accident ___ Return to Duty
___ Follow Up ___ Reasonable Suspicion/Cause ___ Other, Specify:_____

**Group Two:** ___ FMCSA ___ FAA ___ FRA ___ FTA ___ PHMSA ___ USCG

☐ Quick Test Drug Screen: **Check One**: ___ 5-panel ___ 7-panel ___ 10-panel

☐ Non-DOT Drug Screen: **Check One**: ___ Pre-employment ___ Random ___ Post Accident
___ Return to Duty ___ Follow up ___ Reasonable Suspicion/Cause

**Check One**: ___ 5-panel ___ 7-panel ___ 10-panel

☐ Breath Alcohol: ☐ DOT ☐ Non-DOT **(Check One)** ___ Pre-employment ___ Post Accident ___ Random ___ Reasonable Cause **(Check One)**

☐ Pulmonary Function Test

☐ Respirator Questionnaire Only

☐ Respirator Fit Test

☐ Audiogram

☐ Functional Skills Assessment

☐ X-Ray, Specify: _____

☐ Lab Work, Specify: _____

☐ Other, Specify: _____

**Company Representative:** _____ _____
Signature Date