

ChIPLEY ChIROPrACTIC OCCUPATIOnAL SERvICES AUTHORIZATION:

Company Name: _____

Date: _____ Employee Name: _____

Supervisor / Designated Employee Representative (DER): _____

Phone Number: _____ Fax Number: _____

Please indicate the reason for the test:

- Pre-Employment Random Reasonable Suspicion
 Post-Accident Return to Duty Follow Up

Authorization to Provide Service and acknowledgement of Company Responsibility to pay for associated services:

Signature of Supervisor/ DER

 Commercial Drivers License (CDL) Medical Fitness Exam

 Pre-Employment Physical with Lift Test

 COMBO 11-panel Urine (WV Miner's OMHST) Drug & Alcohol Test Combo

Urine Specimen Collection for Drug Screening:

Check One: DOT 5-panel drug test Non-DOT 11-panel drug test
 Non-DOT 5-panel drug test Rapid Screening(Non-Lab Add-On)

 Evidential Breath Alcohol Test (BAT)

Check One: DOT Test Non-DOT Test (Follow DOT Protocols)

 Add On Chest X-rays with Radiology Report

 Other Testing (Please write test):

(Questions: Call us at 304-252-0200) Please send this form with the employee **or** Fax it to us in advance of their arrival at 304-252-0256 **or** Email it to drc@whiplashpro.com