____Danbury MPR: 100 Mill Plain Rd, Danbury, CT 06811| Tel: 203.826.2600 | Fax: 203.826.8266
____Danbury NR: 76 C Newtown Rd., Danbury, CT 06810 | Tel: 203.826.8434 | Fax: 203.826.8433
____Norwalk: 607 Main Ave., Norwalk CT 060851 | Tel: 203.845.9100 | Fax: 203.845.9600
____New Britain: 135 East Main St., New Britain, CT 06051 | Tel: 860.357.6899 | Fax: 860.357.6898
____West Hartford: 1030 Boulevard, West Hartford, CT 06119 | Tel: 860.986.6440 | Fax: 860.986.6439
____Vernon: 179 Talcottville Rd., Vernon, CT 06066 | Tel: 860.987.7600 | Fax: 860.986.7601

Employer Authorization for Examination or Treatment

Please email or fax this and all completed forms to the clinic listed above or send with employee

Patient's Name: ____________________

Patient's Job Title: ____________________ Date: ____________________

EMPLOYER REPRESENTATIVE *Please complete all information in this section before sending employee for treatment or services.*

Employer Name: ____________________ Employer Contact: ____________________

Employer Address: ____________________ Employer Contact Phone: ____________________

City: __________ State: ______ Zip: ______ Employer Contact Fax: ____________________

WORKERS'COMP ☐ Protocol for Injury ☐ Protocol for Illness Bill to: ☐ Company/Employer: ☐ WC Carrier

WC Carrier Name: ____________________ Phone: __________ Fax: __________

Address: ____________________ City/State/Zip: ____________________

Date/Time of Injury/Illness: ____________________ W/C Claim #: ____________________

AUTHORIZED SERVICES *(Please select visit type and applicable services below.)* ☐ Workers' Comp ☐ Occupational Medicine

PHYSICALS	DRUG SCREEN	DRUG AND ALCOHOL — DOT	DRUG AND ALCOHOL — NON-DOT	OTHER SERVICES
		Please Select Chain of Custody: ☐ Employer CCF ☐ Clinic CCF ☐ ePassport ☐ Other: Specify______		
____Return to Work	____Random	____Breath Alcohol	____Breath Alcohol	____Spirometry
____Pre-Employment Physical	____Pre-Employment	____Urine Drug Screen	____In-House Rapid (5 Panel)	____Audiometry (Hearing Test)
____Annual Physical	____Return to Work	____Other:__________	____In-House Rapid (10 Panel)	____Snellen (Vision Exam)
____DOT Physical	____Follow-Up		____Collection Only	____Ishihara (Color Blind Test)
____DOT Recertification	____Reasonable Suspicion		____Hair Drug Screen	____OSHA Respirator Questionnaire
____Fit for Duty	____Periodic Review		____Other:__________	____Respirator Fit Test
	____Post Accident			____Chest X-Ray
				____EKG

IMMUNIZATION SERVICES AND LABORATORY TESTING

____PPD/Tuberculosis Skin Test - 1 -Step	____Vaccine - Influenza	____CBC	____Post Exposure
____PPD/Tuberculosis Skin Test - 2 –Step	____Vaccine - Pneumonia	____CMP	Other Lab Services - Specify Below
____Quantiferon Gold TB Blood	Other Vaccines - Specify Below	____Urinalysis	Covid-19 PCR to lab ______
____Vaccine - Hep A:____1st____2nd (180 days)	____________________	____Titer - Hepatitis A	Covid-19 Rapid Test
____Vaccine-Hep B:___1st___2nd(30 days)___3rd(180 days)	____________________	____Titer - Hepatitis B	
____Tetanus:____TD____Tdap			

______________________________ ______________________________

Signature of Authorized Representative **Date/Time**