



WORKFIRST Authorization Form

COMPANY NAME: _____

COMPANY PHONE #: _____

AUTHORIZED BY: _____ (Print Name)

(Signature)

EMPLOYEE NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

STATE: _____ ZIP: _____

TELEPHONE NUMBER: _____

JOB TITLE: _____

PLEASE CHECK ALL REQUESTED SERVICES

TYPE OF PHYSICAL:

- Pre-placement
- Periodic Physical (Annual)
- Driver Physical (DOT)
- School Bus Physical
- Combination (DOT & School Bus)
- Respirator Physical
- Executive Physical
- Medical Surveillance Physical
- Fitness for Duty
- Travel

TYPE OF TESTING REQUESTED:

- Audiogram
- Pulmonary Function Test (Spirometry)
- PPD (TB test)

**DRUG AND ALCOHOL TESTING
MUST HAVE PHOTO ID**

DOT

- | | | |
|---|-------|--|
| <input checked="" type="checkbox"/> one service | (and) | <input checked="" type="checkbox"/> one reason for testing |
| <input type="checkbox"/> DOT Urine Drug | | <input type="checkbox"/> pre-employment |
| <input type="checkbox"/> DOT Alcohol | | <input type="checkbox"/> post accident |
| | | <input type="checkbox"/> random |
| | | <input type="checkbox"/> for cause |
| | | <input type="checkbox"/> follow up |

NONDOT

- | | | |
|---|-------|--|
| <input checked="" type="checkbox"/> one service | (and) | <input checked="" type="checkbox"/> one reason for testing |
| <input type="checkbox"/> NONDOT Urine Drug | | <input type="checkbox"/> pre-employment |
| <input type="checkbox"/> NONDOT Saliva Drug | | <input type="checkbox"/> post accident |
| <input type="checkbox"/> RAPID 5 Drug | | <input type="checkbox"/> random |
| <input type="checkbox"/> RAPID 9 Drug | | <input type="checkbox"/> for cause |
| <input type="checkbox"/> NONDOT Breath Alcohol | | <input type="checkbox"/> follow up |

IMMUNIZATIONS:

- | | |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> TWINRIX |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hepatitis A | |

APPOINTMENT INFORMATION

Workers Compensation Injury

Date of injury: _____

Description of injury: _____

Appointment Preferences

Location preferred

- | | |
|--|---|
| <input type="checkbox"/> WORKFIRST
2250 East Market St.
York, PA 17402
Phone: 717-851-1600
Fax: 717-851-1650 | <input type="checkbox"/> WellSpan Adams Health Ctr
40 V Twin Dr.
Suite #205
Gettysburg, PA 17325
Phone: 339-2880
Fax: 339-2792 |
|--|---|

M-Th 7am- 7pm
Fri 7am- 5pm
Sat 8am- 12 noon

M-F 8am- 4:30pm

Day(s) of week preferred: M T W TH F SA

Circle preference(s)

Time of Day preferred: _____

EMPLOYEE WILL CALL FOR APPOINTMENT

Special instructions: _____

WORKFIRST OFFICIAL USE ONLY

Appt. Date: _____

Appt. Time: _____