

AUTHORIZATION TO PROVIDE SERVICES

AUTHORIZATION INFO	<u></u>
Authorized by (signature)	SERVICES AUTHORIZED
Authorized by (print name)	DRUGS SCREENS
Authorizer's Phone Number	[] Standard 5 panel Non-DOT drug screen
Date of Authorization	
EMPLOYERS INFO	
Company Name	REASON
Company Phone	[] Pre-employment [] Random [] Post Accident [] Other
Company Fax	
Address	
	For DOT drug screen or collection DOT agency is required: [] FMCSA [] FAA [] FRA [] FTA [] PHMSA [] USCG
PATIENT INFO	
Patient Name	PHYSICALS
Tel	[] DOT Physical
SS#	[] Basis pre-employment physical
Date of Birth	
[] Check box if employee to pay for services	
RESULTS REPORTING TO	OTHER SERVICES [] Rapid covid test
Contact Name	[] TB Test
[] Fax Number	[] BAT Alcohol Test
[] E-Mail Address	

Location: 4385 N Pecos Rd. Suite 140 Las Vegas NV 89115 Monday - Thursday 8:00 am to 5:00 pm & Friday 8:00 am to 12:30pm * Last Urine Drug is 2 Hours Before Closing *