



State of Maryland

Authorization for Examination or Treatment

(Patient Must Present Photo ID at Time of Service)

Agency: _____

(List Agency or Sub-Agency to Receive Invoice)

Today's Date: _____

Appointment Date/Time (if any): _____

Location: _____

Authorized By: _____

Agency Phone No.: _____

Agency Fax No: _____

Employee: _____

Employee Date of Birth: _____

Please check all that apply:

Work Injury/Illness Date of Injury _____ Claim# (if available) _____

Physical Examination

Pre-placement Pre-placement w Ergonomic Assessment DOT - Regulated

Fitness for Duty/Ability to Work Medical Surveillance FAA - MDOT

Other: _____

Substance Abuse Testing

DOT - Regulated Drug Test MDOT Non-regulated Drug Test

DOT - Regulated Alcohol (Breath) MDOT Non-regulated Alcohol Test (Saliva)

Other: _____

Reason for Substance Abuse Testing

Pre-employment Reasonable Suspicion Post-accident Random

Follow-up Return to Duty

Psychological Services (scheduled through WORKPRO Elkridge MD location)

Psychological Testing SAP Critical Incident Management

Other Services

Respirator Fit Test Audiogram PPD Pulmonary Function Test EKG

Chest X-ray Vaccination: _____ Other: _____

Special instructions/comments _____

