The University of Texas at Austin
UT Health Austin

Employer Authorization Questionnaire

Date: _____

Employer Information

Company Information

Name: _____

Business Industry: _____

Address: _____

City/State/Zip: _____

Website: _____

Employee Contact

Contact Information

Name: _____

Position: _____

Supervisor: _____

Phone: (_____) _____

Email: _____

Service Needs

Required Services

☐ Pre-placement ☐ Reasonable Suspicion ☐ Random

☐ Post-Accident ☐ Follow-up ☐ UDS

☐ Client will send CCF with patient

Testing Agency

☐ FRA ☐ FMCSA ☐ FTA ☐ PHMSA ☐ Coast Guard

Substance Abuse Testing

☐ Non-regulated UDS ☐ Regulated UDS ☐ Hair Collect

☐ Send Out ☐ Will send CCF with patient ☐ Rapid

☐ 5 Panel ☐ 9 Panel ☐ 10 Panel ☐ 11 Panel

Alcohol Testing

☐ Breath Alcohol Testing

Physical

☐ DOT Pre-Placement ☐ DOT recertification

☐ Pre-placement ☐ Annual ☐ Exit ☐ Hazmat

☐ Asbestos ☐ Fit for Duty ☐ Return to Duty

Immunization

☐ Hep B ☐ Flu ☐ Tetanus ☐ TDAP ☐ Other _____

Blood Draw

☐ Heavy metals panel ☐ CNC ☐ CMP ☐ Other _____

Additional Components

☐ Snellen Vision

☐ Vitals ☐ Audiogram

☐ TB 1 Step ☐ TB 2 Step

☐ EKG ☐ X-ray Chest 1 view ☐ X-ray Chest 2 view

☐ X-ray Back ☐ Other _____

Injury Care

Worker's Compensation Carrier: _____

Address: _____

City/State/Zip: _____

Phone: (_____) _____

Policy Number: _____

Effective Date: _____ Exp. Date: _____

Claim Adjuster: _____

☐ Post-Accident Regulated UDS

☐ Client will send CCF with patient

☐ Post-Accident Non-Regulated UDS

☐ Instant ☐ Send out ☐ Client will send CCF with patient

☐ 5 Panel ☐ 9 Panel ☐ 10 Panel ☐ 11 Panel

☐ Specialty Panel

☐ Post-Accident Alcohol Test (Breath/Blood)

☐ Light Duty Available

☐ Request phone to discuss restrictions

On-site Services

☐ PPD ☐ Flu ☐ Other _____

Results

Username: _____

Password: _____

The University of Texas at Austin
UT Health Austin

Employer Authorization for Treatment or Examination

Date: _____

Employee Information

Name: _____

Date of Birth: _____

Social Security Number: _____

Phone: (_____) _____

Email: _____

Address: _____

Job Title & Description: _____

Employer Information

Company Name: _____

Address: _____

_____

Supervisor: _____

Phone: (_____) _____

Email: _____

Reason for today's visit

- ☐ Drug Screen
- ☐ Immunization
- ☐ Physical
- ☐ DOT Physical
- ☐ Other _____

Injury Information

Location when the injury occurred: _____

_____

Date & Time of injury: _____

Date employer was notified of injury: _____

Please describe in detail how the injury happened: _____

_____

_____

_____

_____

Billing information

☐ Bill **EMPLOYER** for Services ☐ Bill **EMPLOYEE** for Services

Carrier: _____

Policy Number: _____

Carrier Phone: _____

Carrier Address: _____

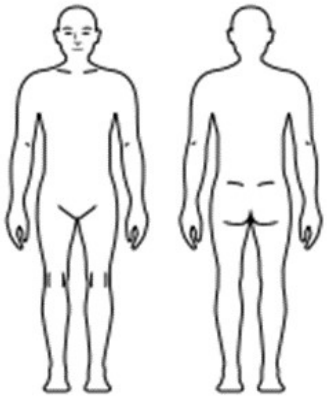
Authorized by: _____

Title: _____

Contact Name: _____

Phone: (_____) _____

Circle the areas where you are injured



What part(s) of your body is injured?

_____

_____

_____

_____

_____

_____

_____

☐ Yes ☐ No Have you filed a claim? Claim No: _____

☐ Yes ☐ No Do you have attorney representation?

☐ Yes ☐ No Have you been previously treated for previously elsewhere for this injury?

If yes, physician name/facility: _____

_____

List any pre-existing conditions that you have had before this injury & for how long you have been treated for these conditions?

_____

_____

I certify that the information provided is correct to the best of my knowledge. I will not hold Dell Medical School, its health providers, or its employees responsible for any errors or omissions that I may have made in completing the information on this form. Additionally, in the event that my worker's compensation carrier or employer denies my claim, I understand that I am responsible for the reimbursement of medical services received.

Employee Printed Name: _____

Employee Signature: _____

Authorized by (Printed Name): _____

Authorized by (Signature): _____