ELECTRA MEMORIAL HOSPITAL LABORATORY/ ELECTRA MEDICAL CLINIC
DRUG SCREENING & PHYSICALS – AUTHORIZATION FORM

Employer or DER: complete the form below

Employee______________________________Social Security# xxx-xx________DOB__________
Age/Gender/Race________________________________ Marital Status________________
Address________________________________City/State________________ZipCode_______
Occupation____

Random_____ Employment ____ Return to Work_____ Accident_____ Suspicion_____

Urine Drug Screen_________ (CDL) Physical_________
Fax 940-495-4137 **Fax: 940-495-3171**

Payment responsibility:

Employer_______ Third Party Administrator/Consortium_______ Employee______

Employer/Third Party____
Street Address____ P. O. Box# __________
City/State____ZipCode______________
Phone# ______________________________ Fax # ______________________________
Employer / DER Contact(HumanResource)_______________________________________
If different from above
Street Address____P.O. Box# _________
City/State____ZipCode___________
Phone# ______________________________Fax # _______________________________

______________________________________ __________
Company representative / DER Signature **Date**

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Self – payment Employees - ONLY

Name___________________________SS# xxx-xx-_____________DOB________________
Age/Gender/Race________________________________ Marital Status________________
Address_______________________________City/State________________ZipCode_______
PHONE # 's:
Home_________________________Cell# ______________________Work________________
Occupation____

Urine Drug Screen______ Routine physical ______

Do you have an appointment in the Clinic: yes / no
Reason for Appointment____
Do you have a **CDL driver's license**: yes / no