530 Suite D Forest Parkway
Forest Park, GA 30297
Phone: 770-545-2052/Fax: 678-701-3120
Email: Admin@clearmedicalconcepts.com

TREATMENT AUTHORIZATION

Date: ______________________________

Employee: ____
(Company Name)

Employer: ____
(Address)

Phone: ____

Email: ____

Authorized By: ____
Name & Title (Please Print)

____
Signature

Service(s) Requested:

☐ Urine Drug Screen ___ DOT ___ NON DOT
__ 5 panel or ____ 10 Panel

☐ Breath Alcohol Test ___DOT ____ NONDOT

☐ DOT Physical

☐ Pre Employment Physical

☐ Post Injury or return to work Physical

____

Reason for Drug Screening:

__Pre-employment __ Random __ Post Accident __Probable Cause
__ Return to Duty

**** Note to Employer: Please fax form and send with employee for all services required.**

Clear Medical Concepts

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Walk- in hours 9am-5pm.

Last pre-employment drug screen starts at 4pm due to 3 hour time limit.

Photo Identification is required for all drug screens, breath alcohol, or DOT physical