

Sutter Occupational Health Services

Treatment Authorization *Please print*

Date _____

Employee _____

Employer _____

Employer Address _____

Phone _____ Fax _____

- Physical Exam DMV/DOT Physical Exam Breath Alcohol Test (BAT)
 Non-DOT Drug Screen DOT Drug Screen TB (PPD Test)
 Other _____

- Work Related injury *Please provide the following information*

Worker's Comp Insurance _____

Policy _____

Effective Date _____ Exp _____

Company Representative

Title

Phone



*Sutter Occupational
Health Services*

Affiliated with the
Sutter Medical Foundation