NDSU
Essentia Health
Here with you

Authorization for Examination or Treatment

PATIENT INFORMATION

Last Name _____ First _____ Middle Initial _____

Date of Birth _____ _____ _____

COMPANY INFORMATION

Name North Dakota State University **Dept #** _____ _____

Address PO Box 6050 City, State, Zip Fargo, ND 58108

STAFFING AGENCY: ___ Yes ___ No If yes, Agency Name: _____

WORK RELATED (SELECT ONE) ___ Injury ___ Illness

** Please indicate in Substance Abuse Testing section if drug or alcohol screen is required post accident.*

PHYSICAL EXAMINATION (SELECT ONE)

DOT Exam
- _____ Preplacement
- _____ Recertification

Preplacement Exam
- _____ Baseline

Special Exam
- _____ Asbestos
- _____ Respirator
- _____ Medical Surveillance

Additional Testing
- _____ Audiogram
- _____ Pulmonary Function Test

SUBSTANCE ABUSE TESTING (SELECT ONE)
*PHOTO I.D. REQUIRED

Drug Screen Type
- _____ DOT Urine Drug Screen (regulated)
- _____ Non-regulated urine drug screen
- _____ Non-regulated urine rapid screen
- _____ Other _____

Alcohol Screen Type
- _____ DOT breath (regulated)
- _____ Non-regulated breath

Reason for screen (select one)
- _____ Annual
- _____ Random
- _____ Return to duty*
- _____ Follow-up*
- _____ Pre-employment
- _____ Post accident/injury
- _____ Reasonable suspicion
- _____ Other _____

*Observed Collection

BILLING INFORMATION (SELECT ONE)

- X Bill Company
- _____ Employee to pay charges
- _____ Third Party Administrator _____
- _____ Worker's Comp _____

AUTHORIZATION

Print Name _____ Date _____

Sign _____

Comments Evaluation of the NDSU Employee Respirator Medical Questionnaire