Adair County Health System
we surround you with care

AUTHORIZATION FOR TREATMENT

Date:			
Employee Name:			
Company Name For Billing			
Address:			
City:		State:	Zip
Authorized By:			

SERVICES REQUESTED	
DOT PHYSICAL	
PRE EMPLOYMENT PHYSICAL	
RANDOM DRUG SCREEN	
RANDOM ALCOHOL SWAB	
POST ACCIDENT DRUG SCREEN	
POST ACCIDENT EXAM & TREATMENT	
SPECIAL INSTRUCTIONS (BELOW):	
This form to be presented to **Adair County Health System** at time of Service	