AFC New England Locations:
MA:
Springfield, West Springfield, Saugus, Dedham, New Bedford, Worcester, Natick, Marlborough, Malden
CT:
Danbury Main, Danbury West, Danbury East, Norwalk, West Hartford, New Britain, Vernon, Torrington, Rocky Hill, Southington

Employer Authorization for Examination or Treatment

Please email or fax this and all completed forms to the clinic listed above or send with employee

Patient's Name: _____

Patient's Job Title: _____ Date: _____

EMPLOYER REPRESENTATIVE *Please complete all information in this section before sending employee for treatment or services.*

Employer Name: _____ Employer Contact: _____

Employer Address: _____ Employer Contact Phone: _____

City: _____ State: Zip: _____ Employer Contact Fax: _____

WORKERS'COMP ☐ Protocol for Injury ☐ Protocol for Illness Bill to: ☐ Company/Employer: ☐ WC Carrier

WC Carrier Name: _____ Phone: _____ Fax: _____

Address: _____ City/State/Zip: _____

Date/Time of Injury/Illness: _____ W/C Claim #: _____

AUTHORIZED SERVICES *(Please select visit type and applicable services below.)* ☐ Workers' Comp ☐ Occupational Medicine

PHYSICALS
___Return to Work
___Pre-Employment Physical
___Annual Physical
___DOT Physical
___DOT Recertification
___Fit for Duty

DRUG SCREEN
___Random
___Pre-Employment
___Return to Work
___Follow-Up
___Reasonable Suspicion
___Periodic Review
___Post Accident

DRUG AND ALCOHOL

DOT	NON-DOT
Please Select Chain of Custody:	
☐Employer CCF ☐Clinic CCF ☐ePassport ☐Other: Specify	
___Breath Alcohol	___Breath Alcohol
___Urine Drug Screen	___In-House Rapid (5 Panel)
___Other:_____	___In-House Rapid (10 Panel)
	___Collection Only
	___Hair Drug Screen
	___Other:_____

OTHER SERVICES
___Spirometry
___Audiometry (Hearing Test)
___Snellen (Vision Exam)
___Ishihara (Color Blind Test)
___OSHA Respirator Questionnaire
___Respirator Fit Test
___Chest X-Ray
___EKG

IMMUNIZATION SERVICES AND LABORATORY TESTING

___PPD/Tuberculosis Skin Test - 1 -Step
___PPD/Tuberculosis Skin Test - 2 –Step
___Quantiferon Gold TB Blood
___Vaccine - Hep A:___1st___2nd (180 days)
___Vaccine-Hep B:___1st___2nd(30 days)___3rd(180 days)
___Tetanus:___TD___Tdap

___Vaccine - Influenza
___Vaccine - Pneumonia
Other Vaccines - Specify Below
_____
_____

___CBC
___CMP
___Urinalysis
___Titer - Hepatitis A
___Titer - Hepatitis B

___Post Exposure
Other Lab Services - Specify Below
Covid-19 PCR to lab _____
Covid-19 Rapid Test

Signature of Authorized Representative _____ Date/Time _____