



8505 Old Dairy Road • Juneau, Alaska 99801 • Tel: 907-790-4111 • Fax: 907-790-3111

Employer Paid Services Authorization Form

Employee(s) Receiving Services: _____ DOB: _____

**If multiple employees, please state see attached list and include a list of name and DOB's

Date(s) Services are Authorized: _____

Services Authorized:

- | | |
|-----------------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> CDL Exam (\$245) | <input type="checkbox"/> Hair Follicle Test (\$125) |
| <input type="checkbox"/> Merchant Marine Physical Exam (MMPE) (\$205) | <input type="checkbox"/> Chest Xray (\$195) |
| <input type="checkbox"/> TB Skin Test (\$188) | <input type="checkbox"/> Respirator Fit Test (\$ 75) |
| <input type="checkbox"/> Rapid Drug Screen (\$125) | <input type="checkbox"/> o w/ Health Questionnaire (\$75) |
| <input type="checkbox"/> DOT/Federal Drug Screen w/ COC (\$125) | <input type="checkbox"/> Audiogram (\$77) |
| <input type="checkbox"/> NONDOT/nonfederal Drug Screen w/ COC (\$125) | <input type="checkbox"/> Vaccinations (please specify) |

Other Services: _____

Special Instructions: _____

Please provide the information for billing purposes:

Company Name: _____

Company Address: _____

Contact person: _____

Phone: _____

Please check the box on how you want to receive your result/s

- Email _____
- Fax _____
- Mail _____

By signing this authorization, we are agreeing to pay Juneau Urgent & Family Care for all the services rendered.

Authorized Signature: _____ Date: _____

Name/Title: _____