

LAKE SHAWNEE
3310 SE 29th St
Suite 300
Topeka, KS 66614
Phone (785) 588-4890 Fax: (785) 730-2637

WANAMAHER
2641 SW Wanamaker Rd
Suite 150
Topeka, KS 66614
Phone: (785) 272-2161 Fax: (785) 272-1970

BREWSTER
1101 Southwest 29th St
Topeka KS 66611
Phone: (785) 596-6088 Fax: (785) 730-2680

AUTHORIZATION FORM

Send the form with your employee or fax it to: (785) 272-1970

DATE: _____

EMPLOYEE NAME: _____ DATE OF INJURY: _____

COMPANY NAME: Auburn Washburn USD 431 PHONE: 785-339-4000

COMPANY ADDRESS: 5928 SW 53rd St FAX: 785-339-4027

CITY: Topeka STATE: KS ZIP: 66610 PO/JOB #: _____

SUPERVISORS NAME: _____ PHONE: _____

SEND REPORTS VIA: FAX _____ E-MAIL _____

MAIL _____ OTHER _____

****SERVICES RENDERED ON CHECKED ITEMS ONLY****

<p><u>PHYSICAL EXAMS</u></p> <p><input type="checkbox"/> DOT Physical <input type="checkbox"/> Non-DOT <input type="checkbox"/> Hazardous Waste <input type="checkbox"/> Crane Operators <input type="checkbox"/> Merchant Mariner/CG <input type="checkbox"/> Other _____</p> <p><u>REASON FOR TEST</u></p> <p><input type="checkbox"/> Pre-Employment <input type="checkbox"/> Annual <input type="checkbox"/> Random <input checked="" type="checkbox"/> Post-Accident <input type="checkbox"/> Reasonable Cause <input type="checkbox"/> Follow-Up <input type="checkbox"/> Return to Duty <input type="checkbox"/> Other _____</p> <p><u>WORK COMP INJURY</u></p> <p><input type="checkbox"/> Bill Above Named Company <input checked="" type="checkbox"/> Bill Insurance Carrier</p> <p><u>Insurance Carrier Info:</u> Name: <u>KASB Workers Compensation Fund</u> Address: <u>1420 SW Arrowhead Rd</u> Phone: <u>785-271-4533</u> Adjuster: <u>Liz Maisberger-Clark</u> Claim #: _____</p> <p>*It is the responsibility of the company to call in a First Report of Injury (Form IA-1) to your workers compensation insurance carrier.</p>	<p><u>URINE DRUG SCREEN</u></p> <p><input type="checkbox"/> DOT (CDL) * <input type="checkbox"/> Non-DOT <input type="checkbox"/> DOT Collection Only * <input checked="" type="checkbox"/> Non-DOT Collection Only <input type="checkbox"/> Quick Screen <input type="checkbox"/> OBSERVATION required for drug screen</p> <p><u>HAIR SAMPLE DRUG SCREEN</u></p> <p><input type="checkbox"/> Psychomedics <input type="checkbox"/> Quest</p> <p><u>ALCOHOL TESTING</u></p> <p><input type="checkbox"/> DOT <input type="checkbox"/> Non-DOT <input type="checkbox"/> Breath <input type="checkbox"/> Saliva</p> <p>*ALL DOT DRUG SCREENS MUST SPECIFY TESTING AGENCY</p> <p><input type="checkbox"/> HHS <input type="checkbox"/> NRC <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG</p>	<p><u>TEST</u></p> <p><input type="checkbox"/> Audiogram <input type="checkbox"/> Pulmonary <input type="checkbox"/> Respirator Fit (Type of Mask) _____</p> <p><input type="checkbox"/> Chest X-Ray (1 view) <input type="checkbox"/> Chest X-Ray (2 views) <input type="checkbox"/> EKG <input type="checkbox"/> Lumbar X-Ray (2 views) <input type="checkbox"/> Lumbar X-Ray (3 views) <input type="checkbox"/> Lumbar X-Ray (5 views) <input type="checkbox"/> Eye Exam Only <input type="checkbox"/> Cervical X-Ray (2 views) <input type="checkbox"/> Cervical X-Ray (5 views) <input type="checkbox"/> Other: _____</p> <p><u>INJECTIONS</u></p> <p><input type="checkbox"/> Flu Vaccine <input type="checkbox"/> Hepatitis B Vaccine <input type="checkbox"/> Tetanus Shot <input type="checkbox"/> TB Skin Test <input type="checkbox"/> Other: _____</p> <p><u>LABORATORY TEST</u></p> <p><input type="checkbox"/> Industrial Chem <input type="checkbox"/> CBC <input type="checkbox"/> Lead Blood <input type="checkbox"/> ZPP (Zinc) <input type="checkbox"/> HIV <input type="checkbox"/> Other: _____</p>
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AUTHORIZED BY: Chelsea Clark
(PRINT NAME)

TITLE: Executive Director of Human Resources
(REQUIRED)