



Northshore Redi-Med, LLC  
 4430 Hwy 22, Mandeville, LA 70471  
 Phone: (985) 626-3470  
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 Email: info@northshoreredimed.com

**Employer Authorization Form**

Employee Name: \_\_\_\_\_

Company Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Person Authorizing Visit: \_\_\_\_\_ Title: \_\_\_\_\_

Signature of Person Authorizing: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_ Direct Phone #: \_\_\_\_\_

Results to be:  Emailed \_\_\_\_\_  Faxed: \_\_\_\_\_

**Reason for visit:**

Pre employment  Random  Reasonable Suspicion/cause  Post accident  Return to duty  Follow up  Other

**Drug screen:**

- USCG
- DOT
- non-DOT
- non-DOT extended
- non-DOT w/K2 Spice
- Rapid 10\*
- Oral Fluid Collection only
- Hair Test Collection only
- Urine Collection only

\*Non-negative send outs will be an additional

**Immunizations:**

- Hepatitis B
- MMR
- Meningococcal
- Td
- Tdap
- Immunization records

**Blood work:**

- Hepatitis panel
- MMR
- Varicella
- TB GOLD

**Physical:**

- non-DOT
- non-DOT extended
- DOT
- USCG

**Additional:**

- Agility Test
- Lift Test
- Pulmonary Function Test
- Audiometric Testing
- Injury/Post-Accident
- Breath Alcohol Test
- PPD(TB Skin Test)

Upon completion of service, \_\_\_\_\_ agrees to pay North Shore Redi-Med for services rendered and requested. You agree for our billing department to have a payment method on file to ensure prompt payment for our services.

**Workers Compensation Information**

Insurance Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Ext. Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Claim or Policy Number \_\_\_\_\_

Hospital Preference (If necessary) \_\_\_\_\_