INNOVATIVE
A Risk Management Company

2714 Canal Street, Suite 102
New Orleans, LA 70119
P: 504.309.2104
F: 504.309.2206

EMPLOYER'S AUTHORIZATION FORM

Donor Must Present Photo ID at Time Service is Rendered

TO BE COMPLETED BY EMPLOYER

DONOR INFORMATION

Donor's Name: _____ SSN: _____

Donor's DOB: _____ Date of Injury: _____

EMPLOYER INFORMATION

Company Name: CSS, Inc./Property One

Address: 20 East Clementon Road, Suite 201

City/State/Zip: Gibbsboro, NJ 08026

Temporary Staffing Agency (if applicable): _____

PLEASE SELECT ALL THAT APPLY

SUBSTANCE ABUSE EVALUATION	TYPES OF SUBSTANCE ABUSE TESTING
____ Hair Collection	____ Follow up
____ DOT Regulated Drug Screen	____ Hair Collection
____ Non-regulated Drug Screen	____ Pre-Employment
____ Urine Collection ONLY	____ Post-Accident
____ Breath Alcohol	____ Promotion
____ Other	____ Random
____ Other	____ Reasonable Cause
	____ Periodic

WORK-RELATED INJURY/ILLNESS

POST ACCIDENT SUBSTANCE ABUSE TESTING:

____ Breath Alcohol
____ Breath Alcohol and Urine Collection
____ Urine Collection

TEST TYPE

____ DOT Regulated Drug Screen
____ Non-Regulated Drug Screen

BILLING

____ Bill Employer Account for Services ____ Employee to Pay at Time of Service

____ Bill Worker's Compensation Carrier: _____
CARRIER NAME

Policy No. _____ Phone No. _____

Address: _____ City/State/Zip: _____

_____ _____ _____
Employer/Authorized Representative Signature Title: Date:

_____ _____ _____
Print Name: Email: Phone: