

ON-SITE AUTHORIZATION FORM

Company Name: _____ Number of Employees: _____

Contact Name: _____ Contact Number: _____

Requesting: _____ Date: _____ Time: _____

* There will be a \$150 On-Site Fee

* Please fax this form to HEALTHremède

* The contact person listed above will be contacted to make On-Site arrangements

DRUG SCREENS COLLECTION				
☐ DOT	☐ Pre-Employ	☐ Random	☐ P/A	☐ Other
☐ NON DOT	☐ Pre-Employ	☐ Random	☐ P/A	☐ Other

BREATH ALCOHOL				
☐ DOT	☐ Pre-Employ	☐ Random	☐ P/A	☐ Other
☐ NON DOT	☐ Pre-Employ	☐ Random	☐ P/A	☐ Other

INJECTIONS		
☐ Flu	☐ Hepatitis A	☐ Hepatitis B
☐ TB	☐ Pneumonia	

☐ Other:
