**LAUSD Food Services Division**
**Treatment Authorization Slip**

| | |
|---|---|
| **Site Address:** | |
| **Date:** | |
| **Time:** | |
| **Patient Name:** | |
| **Date of Injury:** | |
| **Authorized By:** | |
| **Title:** | |
| **Phone #:** | |
| **Signature:** | |

**SERVICES REQUESTED**

| | |
|---|---|
| | Health Clearance (free from communicable disease)[1] |
| | Fitness For Duty |
| | *Reasonable Suspicion* NON DOT Breath Alcohol and Drug test[2] |
| | *Return to work* NON DOT Breath Alcohol and Drug test[2] |

*Special Instructions/Comments:*

1 – Please complete LAUSD Form P-38.272 2009-01 FSD Health Appraisal Form
2 – Any initial drug test that is positive must be sent for a confirmation GCMS test**.**
Please **fax** the test results the confidential fax at 213-241-8476 and mail the originals to
**LAUSD-FSD HR Department (Confidential)**
333 S. Beaudry Ave., 28th Floor
Los Angeles, CA 90017

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