

| 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: | |
| <p>1 – Please complete LAUSD Form P-38.272 2009-01 FSD Health Appraisal Form</p> <p>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)</p> <p>333 S. Beaudry Ave., 28th Floor Los Angeles, CA 90017</p> | |

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