University Hospitals

Occupational Health Services

Employer's Authorization for Examination or Treatment

(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

Patient Name _____ SSN _____

Date of Birth _____ Date of Injury _____

Company _____ Address/Location _____

Temporary Staffing Agency _____

Work-Related:
☐ **Injury** ☐ **Illness**

Substance Abuse Testing:
☐ Drug Screen
- ☐ DOT ☐ NON DOT
- ☐ 5 Panel ☐ 10 Panel

☐ Breath Alcohol

☐ Urine Collection Only

Billing:

☐ Bill company for services
☐ Employee to pay at time of service
☐ Bill Workers' Compensation Carrier

Carrier: _____

Policy Number: _____

Phone: _____

Address: _____

Physical Examinations

Job Title: _____

Test Type:
☐ Post Offer
☐ Annual
☐ DOT Preplacement
☐ DOT Recertification
☐ Physical Exam
☐ Respirator Fit Test
☐ Respiratory Physical
☐ Hazmat
☐ Return to Work
☐ BUS
☐ BUS w/DOT Physical
☐ Other: _____

Substance Abuse Testing:

☐ Regulated
☐ Nonregulated (non-DOT)
- ☐ 5 Panel ☐ 10 Panel

☐ Urine Collection Only
☐ Rapid Test
☐ Hair Collection
☐ Breath Alcohol

Test Type:
☐ Pre-employment
☐ Random
☐ Reasonable Suspicion
☐ Post Accident
☐ Follow-up
☐ Return to Duty
☐ Other: _____

Other Services

Test Type:
☐ Flu Shot
☐ TB Skin Test
☐ Hepatitis B Vaccine
☐ PFT (Pulmonary Function Testing)
☐ Audiology Testing
☐ Hepatitis B Antibody
☐ Other: _____

Authorized By _____ Title _____

Phone _____ Date _____