**OCCUPATIONAL HEALTH MEDICAL TREATMENT AUTHORIZATION FORM**

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| **Employee/Employer Information** | | | |
| **Employee Name:** | | **SSN or ID Number:** | |
| Employer Name: | | | |
| Employer Address: | | | |
| Employer City: | Employer State: | | Employer Zip Code: |
| Employer Phone: | | Employer Fax: | |

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| **Third Party Administrator (TPA) Information** | | | |
| **TPA Name:** | | | |
| TPA Address: | | | |
| TPA City: | TPA State: | | TPA Zip Code: |
| TPA Phone: | | TPA Fax: | |

**Check All Applicable Treatment/Testing Authorized**

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| **PHYSICAL EXAMINATION** | **VACCINATIONS / IMMUNIZATIONS** |
| 🞎 DOT physical exam  🞎 Pre-placement physical exam  🞎 Fitness for duty  🞎 OSHA respirator physical (PFTs and exam)  🞎 FIT Test (mask) | 🞎 Hepatitis B vaccination – 3 part series  🞎 Tetanus  🞎 Influenza |

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| **URINE DRUG SCREENS** | **ALCOHOL TESTING** | **ANCILLARY SERVICES** |
| 🞎 5 panel NON DOT  🞎 10 panel NON DOT  🞎 10 panel DOT  🞎 Collection (employee must bring  chain of custody form) | 🞎 Breath Alcohol DOT  🞎 Saliva NON DOT | 🞎 PPD/TB Screening  🞎 Spirometry (PFTs)  🞎 Audiometry  🞎 Lead / ZPP  🞎 EKG  🞎 Vision Screening  🞎 Chest X-Ray – (1) View  🞎 Chest X-Ray – (2) Views  🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **REASON** |
| 🞎 Pre-employment 🞎 Reasonable suspicion 🞎 Return to duty 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Random 🞎 Follow-up 🞎 Periodic |

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| **EMPLOYER AUTHORIZATION** | | | |
| Print Name: | Signature: | | Date: |
| Title: | | Phone: | |
| Fax or Mail Results to: | | | |
| Billing: 🞎 Bill to employer 🞎 Bill to Third Party Administrator 🞎 Work related illness/injury | | | |
| **Additional Comments:** | | | |

**EMPLOYEES MUST BRING FORM FOR AUTHORIZATION TO BILL COMPANY**