**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**