University Hospitals
Occupational Health Services

Employer's Authorization for Examination or Treatment

(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

Patient Name | Date of Birth | SSN | Job Title

Patient Phone Number | Full-Time/Part-Time | Date of Injury

Full Name of Company | Address | Company Box Code (For Drug Results Access)

Physical Examinations

- ☐ Post Offer/Basic
- ☐ OP&F Pension Fund
- ☐ Annual
  - ☐ NFPA ☐ HAZWOPR ☐ Other:
- ☐ HAZMAT
  - ☐ Chagrin/S.E. ☐ Other:
- ☐ DOT
  - ☐ Pre-Employ ☐ ReCertification
- ☐ Bus (T8)
- ☐ Respiratory
- ☐ Asbestos
- ☐ Return To Work
- ☐ Fit For Duty/Assessment
- ☐ Other:

Substance Abuse Testing

- ☐ Pre-Employment
- ☐ Random
- ☐ Reasonable Suspicion
- ☐ Work Related Injury/Illness/ Post Accident
- ☐ Follow-Up/Return To Work
- ☐ Other:
- ☐ Urine Drug Screens
  - ☐ Dot ☐ 5 Panel ☐ 10 Panel
  - ☐ 12 Panel ☐ 5 Panel Rapid
  - ☐ 11 Panel Rapid ☐ Other
  - ☐ W/Nicotine
- ☐ Urine Collection Only
  Send to:
- ☐ Breath Alcohol Test
  - ☐ Regulated ☐ Non-Regulated
- ☐ Hair Collection

Other Services

- ☐ BWC Injury/Followup Care
- ☐ Respirator Clearance
- ☐ Respirator Fit Test
  - ☐ Qualitative ☐ Quantitative
- ☐ Hepatitis A Vaccine
- ☐ Hepatitis B Vaccine (Series of 3)
- ☐ Hepatitis B Antibody
- ☐ TB Test
  - ☐ Skin ☐ T-Spot
- ☐ Tdap
- ☐ MMR
- ☐ PFT
- ☐ Audiogram
- ☐ Other:

Billing

- ☐ BAT/UDS services as part of injury, illness or follow-up care: Bill the **CORPORATE HEALTH PLAN**
- ☐ Injury Care: Bill the **WORKER'S COMPENSATION CARRIER**

Carrier: _____

Policy Number: _____

Phone: _____

Address: _____

- ☐ Pre-Employment/Annual Occupational Health Services, Random and Reasonable Suspicion UDS: Bill the **CORPORATE HEALTH PLAN**
- ☐ Employee to **SELF-PAY** at the time of service

IS TRANSITIONAL WORK/LIGHT DUTY OFFERED TO THE INJURED WORKER? ☐ Yes ☐ No

Authorized By | Title

Phone | Date