

# WorkHealth

Occupational Medical Center

**Employee Name:** \_\_\_\_\_

**Employer** \_\_\_\_\_

**Job Title:** \_\_\_\_\_

**FACILITY ADDRESS**

|  |  |
|--|--|
| <p><b>Work-related – Date of Injury-</b> _____</p> <p><input type="checkbox"/> Injury<br/><input type="checkbox"/> Illness</p> <p><b>Drug Testing Options</b></p> <p><input type="checkbox"/> DOT FMCSA__ PHMSA__ FAA__ FRA__ FTA__<br/><input type="checkbox"/> Non-DOT USCg__</p> <p><b>Reason:</b></p> <p><input type="checkbox"/> Post offer/Pre-hire<br/><input type="checkbox"/> Post Injury<br/><input type="checkbox"/> Post Accident<br/><input type="checkbox"/> Reasonable Cause<br/><input type="checkbox"/> Recertification<br/><input type="checkbox"/> Random Drug Screen<br/><input type="checkbox"/> Periodic<br/><input type="checkbox"/> Follow-up</p> <p><input type="checkbox"/> Evidential Breath Alcohol Test</p> | <p><b>Physical Exam Options</b></p> <p><input type="checkbox"/> Post offer/Pre-Hire<br/><input type="checkbox"/> DOT Initial Recert<br/><input type="checkbox"/> Return to Work<br/>Annual</p> <p><b>Other</b></p> <p><input type="checkbox"/> Audiogram<br/><input type="checkbox"/> Back Evaluation<br/><input type="checkbox"/> Chest X-Ray<br/><input type="checkbox"/> EKG<br/><input type="checkbox"/> Lift Test<br/><input type="checkbox"/> Hepatitis B Vaccine<br/><input type="checkbox"/> PPD Test<br/><input type="checkbox"/> Pulmonary Function Test (PFT)<br/><input type="checkbox"/> Tetanus<br/><input type="checkbox"/> Other _____</p> |
|--|--|

**Special Instructions:**

Follow regular protocol for specified job description

\_\_\_\_\_

\_\_\_\_\_

Authorized by: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Please Print)

Phone: (\_\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_

**Consent for Release of Information:**

I hereby authorize **WorkHealth** Occupational Medical Center, its practitioners and staff, to release any information pertinent to this specific injury/illness and/or physical examination and/or drug or alcohol screen results to my Employer, Prospective Employer, Employer's Medical Review Officer, or Third Party Administrator. IN addition, I hereby release **WorkHealth** Occupational Medical Center, its practitioners and staff, from any and all claims of actions resulting from the disclosure of these results.

I hereby give consent to **WorkHealth** Occupational Medical Center, its practitioners and staff, for examination and treatment.

**Employee/Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\* WorkHealth does not collect genetic information  
\*\* WorkHealth does not provide genetic information  
\*\* Picture ID is required for all substance abuse testing/drug screening.  
**\*\* Please do NOT bring children to the clinic**