

WorkHealth

Occupational Medical Center

Employee Name: _____

Employer _____

Job Title: _____

FACILITY ADDRESS

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