OCCUPATIONAL HEALTH/WORKER'S COMP SERVICES

Authorization for Occupational Health/Worker's Comp Services

Employee/Patient Information: *Please complete with the Employee's Full Legal Name*			
Last:	**First:**		**Middle:**
Social Security Number:	**Date of Birth:**	**Sex:** ___ Male ___ Female	**Today's Date:**
Company that sent you for today's visit:			

Services Requested:

____ **Pre-Employment DOT Physical** ____ **General Hearing** ____ **Basic Vision/Color Exam**

____ **Basic Physical Exam** ____ **TB Test** ____ **Tetanus** ____ **Vaccination**
*Please specify which vaccines*____________

____ **Pulmonary Function/Spirometry** ____ **Respirator Fit Testing** ____ **Flu shot**

____ **DOT Drug Screen** ____ **Non-DOT Drug Screen**

Please identify reason for drug screen

____ **Pre-Employment** ____ **Return to work** ____ **Random**
____ **Post-Accident** ____ **Reasonable Suspicion** ____ **Other** ____________________________

____ **Alcohol screening** ____ **blood** ____ **saliva swab** ____ **Other** ________________________________

____ **Workers Comp Evaluation** *(please list specifics of concern)*	**Date of Injury:**

Billing Information: *Please list which division or department should be billed for today's services – If same as company standard please omit this section*
Comments:

______________________________ ______________________________
Signature of Authorizing Individual **Date**

* All requests must be signed for authorization of services

For Well-Key Urgent Care Office Use Only		
Associate who Registered:	**Verification of Authorization Approval:** _____ **yes** _____ **no** **Company Rep. Name who verified:**	**Drug Screen Required:** ___ **yes** ___ **no**