MIDWEST OCCUPATIONAL MEDICINE Ltd

MEDICAL SERVICES AUTHORIZATION

COMPANY:_____ PHONE:_____ FAX:_____

ADDRESS:_____

EMPLOYEE NAME:_____ POSITION:_____

AUTHORIZED BY:_____ DATE:_____

THE COMPANY LISTED ABOVE IS RESPONSIBLE FOR ALL CHARGES ASSOCIATED WITH MEDICAL SERVICES RENDERED

PHYSICAL EXAMINATION (Plese circle exam needed)

☐ Pre-Placement ☐ DOT ☐ Annual ☐ Respirator Clearance ☐ Asbestos ☐ Hazmat ☐ Lead

☐ Merchant Marine ☐ Bus Driver ☐ Silica ☐ Return to Work (Occ) ☐ Return to Work (Non-Occ)

☐ Fit for Duty (Occ) Fit for Duty (Non-Occ) ☐ Other_____

ILLNESS/INJURY

Evaluation and Treatment_____ Describe Nature of Injury_____

Should this illness/injury be determined non-work related the company will be responsible for payment of services rendered prior to notification

URINE DRUG TESTING (Please circle type of test and reason)

TYPE: ☐ DOT ☐ Non-DOT ☐ Panel 5 ☐ Panel 9 ☐ Panel 10 ☐ Instant 5 ☐ Instant 9 ☐ Instant 10

☐ Observed ☐ Urine Collection Only ☐ Hair Collection Only Other_____

REASON: ☐ Pre-Placement ☐ Post Accident ☐ Random ☐ Reasonable Cause ☐ Follow-Up ☐ Annual

EVIDENTIAL BREATH ALCOHOL TESTING (Please circle type of test and reason)

TYPE: ☐ DOT ☐ Non-DOT

REASON: ☐ Pre-Placement ☐ Post Accident ☐ Random ☐ Reasonable Cause ☐ Follow-Up ☐ Annual

VACCINATIONS (Please circle requested item)

☐ TB ☐ Hepatitis A ☐ Hepatitis B ☐ Tetanus Other_____

OTHER MEDICAL SERVICES (Please circle requested item)

☐ Audiometric Test ☐ Spirometry ☐ Post BBP Exposure Evaluation ☐ Laboratory only ☐ Fit Test

IMPORTANT: Please fully complete your form, save the file to your computer, and email your completed form to greeves@midwestoccmed.com and tjurcich@midwestoccmed.com.

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