WorkHealth

Occupational Medical Center

Employee Name: _____

Employer _____ **Job Title:** _____

FACILITY ADDRESS

Work-related – Date of Injury- _____

☐ Injury
☐ Illness

Drug Testing Options

☐ DOT FMCSA☐ PHMSA☐ FAA☐ FRA☐ FTA☐
☐ Non-DOT USCG☐

Reason:

☐ Post offer/Pre-hire
☐ Post Injury
☐ Post Accident
☐ Reasonable Cause
☐ Recertification
☐ Random Drug Screen
☐ Periodic
☐ Follow-up

☐ Evidential Breath Alcohol Test

Physical Exam Options

☐ Post offer/Pre-Hire
☐ DOT ☐Initial ☐Recert
☐ Return to Work
☐ Annual

Other

☐ Audiogram
☐ Back Evaluation
☐ Chest X-Ray
☐ EKG
☐ Lift Test
☐ Hepatitis B Vaccine
☐ PPD Test
☐ Pulmonary Function Test (PFT)
☐ Tetanus
☐ Other _____

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