OMP | OccMed PHYSICIANS

1714 Charlestown New Albany Road
Jeffersonville, IN 47130
(812) 271-4240
admin@occmedphysicians.com

AUTHORIZATION FOR SERVICES

Check all services requested. | **Incomplete forms may delay testing.**

1 EMPLOYEE INFORMATION

Employee Name: _____ Date of Birth: ____/____/_____ Phone: _____

2 COMPANY INFORMATION

Company Name: _____ Phone: _____

Today's Date: _____ / _____ / _____ Expiration Date: _____ / _____ / _____

3 SERVICES REQUESTED

Check all that apply.

DRUG & ALCOHOL TESTING

- ☐ DOT Drug Screen
- ☐ Non-DOT Drug Screen
- ☐ Instant Drug Screen
- ☐ Breath Alcohol Test

REASON (Choose one):

- ☐ Pre-Employment
- ☐ Random
- ☐ Post-Accident
- ☐ Reasonable Suspicion
- ☐ Return-to-Duty
- ☐ Other: _____

PHYSICAL EXAMS

- ☐ Pre-Employment Physical
- ☐ Return-to-Work / Fitness for Duty
- ☐ DOT Certification
- ☐ Respirator Medical Evaluation
- ☐ Other: _____

TB TESTING

- ☐ PPD Skin Test
- ☐ Quantiferon Gold Blood Test
- ☐ Other: _____

OTHER SERVICES

- ☐ Respirator Fit Test
- ☐ Hearing Test (Audiogram)
- ☐ Vaccine(s)
- ☐ Other: _____

4 INJURY TREATMENT (If Applicable)

☐ **Injury Treatment Needed**

If checked, please complete the information below.

Date of Injury: _____ / _____ / _____ Time of Injury: _____ AM / PM

Body Part Injured: _____

Brief Description of Injury: _____

Additional Notes or Special Instructions: _____

5 AUTHORIZATION

I authorize OccMed Physicians to provide the services selected above.

Authorized Company Representative Signature: _____ Date: _____ / _____ / _____

Printed Name: _____ Title: _____