Occupational Medicine Authorization for Treatment

Employee Name: ______________________________ Company Name: ______________________________

Visit Authorized By: __________________________ Phone Number: ____________________________

The purpose for this visit is:

☐ Employment Examination ☐ Workers’ Compensation Injury ☐ Reasonable Suspicion ☐ Random

Employment Examination:

☐ Pre-employment/Post offer Physical ☐ Respiratory Clearance Exam ☐ TB Skin Test
☐ Non-DOT Drug Screen Collection ☐ Respiratory Fit Test (bring your respirator) ☐ TB Quantiferon Gold Blood Draw
☐ Breath Alcohol Test ☐ Pulmonary Function Test ☐ Tetanus Vaccine
☐ DOT Physical ☐ Audiometric Testing ☐ Hepatitis B Vaccine
☐ DOT Drug Screen Collection ☐ Vision Screening – Snellen ☐ Hepatitis B Titer
☐ Flu Vaccine ☐ Vision Screening – Color Blind testing ☐ Rabies Vaccine
☐ COVID-19 Testing ☐ Vision Screening – Titmus (Kernersville only) ☐ Rabies Titer

Other: ________________________________________________________________

*If Pre-employment physical, please indicate any additional services needed with the physical*

Workers’ Compensation:

Date of Injury: ___________________________ Time: ______________________ AM   PM

☐ Post-Accident Non-DOT Drug Screen Collection ☐ Post-Accident Breath Alcohol Test ☐ Exposure
☐ Post-Accident DOT Drug Screen Collection

*Please call clinic to notify staff of employee’s arrival time*

Authorized Signature: ______________________________ Date: ________________

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