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

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Employment Examination:

□ Pre-employment/Post offer Physical

□ Non-DOT Drug Screen Collection

□ Breath Alcohol Test

□ DOT Physical

□ DOT Drug Screen Collection

□ Flu Vaccine

□ COVID-19 Testing

□ Respiratory Clearance Exam

□ Respiratory Fit Test
(bring your respirator)

□ Pulmonary Function Test

□ Audiometric Testing

□ Vision Screening – Snellen

□ Vision Screening – Color Blind testing

□ Vision Screening – Titmus
(Kernersville only)

□ TB Skin Test

□ TB Quantiferon Gold Blood Draw

□ Tetanus Vaccine

□ Hepatitis B Vaccine

□ Hepatitis B Titer

□ Rabies Vaccine

□ Rabies Titer

Other: _____

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

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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

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Authorized Signature: _____ Date: _____

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