Ochsner Occupational Health

Employer Authorization for Examination and/or Treatment

Employee Name _____ Today's Date _____

Date of Birth_____ Date & Time of Injury/ Illness _____

EMPLOYER INFORMATION (*please print*)

Company Name _____ Phone # _____

Address _____ Fax # _____

Person Authorizing Visit _____ Title _____

Signature of Person Authorizing Visit _____ Date _____

Email _____ Direct Phone # _____

REQUESTED SERVICES

□ DOT/CDL □ USCG Physical □ Return to Work Physical □ Treatment for Injury

□ Annual Physical □ Pre-employment Physical □ TB Skin Test □ Audiometry □ EKG □ Agilities Test

□ PFT/ Spirometry □ Respirator Clearance □ OSHA Questionnaire □ Mask Fit Test (circle FULL or HALF face)

□ Immunizations _____ □ Other _____

COMMENTS: _____

DRUG AND ALCOHOL TESTING (*please specify reason*)

□ **DOT specify:**	□ Non DOT 5	□ Non DOT Alcohol (EBT)
□ FMCSA □ FTA	□ Non DOT 10	□ DOT Alcohol (EBT)
□ PHSMA □ FAA	□ Rapid 5 (Same day)	□ HAIR Collection
□ USCG □ FRA	□ Rapid 10 (Same day)	Comments: _____

REASON FOR DRUG AND ALCOHOL TESTING:

□ Pre-Employment □ Random □ Reasonable Suspicion □ Post Accident □ Return to Duty □ Follow-up

BILLING INFORMATION (*please print*)

□ **Bill Company**

Company Billing Address (if different from above)_____

Billing Contact Person _____ Phone # _____

□ **Bill Worker's Comp Carrier**

Worker's Comp Carrier _____ Phone # _____

Address _____ Claim # _____

□ **Other (Please Specify)**_____ **Light Duty Available?** □ Yes □ No