

COMPANY: _____

EMPLOYEE (or Applicant): _____

Social Security #: _____

Job Title: _____

Occupational Health Center is authorized to examine and/or treat the above individual.

PHYSICAL

- Pre-Placement Physical with

- Dept. of Transportation Physical
- Pulmonary Function only
Respirator Fitness Exam
- Audiogram only
Yearly OSHA Test

OFFICE VISIT

- Possible Worker's Comp Injury
Date of Injury _____
Problem _____
- Insurance Information
Claim # _____
Insurer's Name _____
Address _____
Adjuster _____

DRUG/ALCOHOL TESTS

- Urine Drug Screen (COC)
 - Breath Alcohol
 - Urine Drug Screen (DOT)
For persons possessing a CDL
 - Urine Drug Screen -
Drug Free Work Place Net
- Reason for testing the individual:**
- Pre-Placement
 - Random
 - Reasonable Cause
 - Post Accident
 - Other _____

Send results to: _____

Send bills to: _____

WE TRULY APPRECIATE YOU ALLOWING US TO CARE FOR YOUR EMPLOYEES! IF A NEED ARISES OR YOU WOULD LIKE TO DISCUSS THE SERVICES THAT WE PROVIDE, PLEASE CALL US IMMEDIATELY!

Please note that the Employer is responsible for payment of all services that they request. This includes making appointments for possible Work-Comp claims that turn out in the evaluation to not be work-related!

OHC

OCCUPATIONAL HEALTH CENTER, LLC

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