



PORT HURON

Industrial Health

1644 Stone Street
Port Huron, MI 48060
tel (810) 982-8016 | fax (810) 982-3590

Medical Authorization

Date: _____

Please call the clinic before sending an employee for a physical or injury/illness treatment. No call is necessary for drug or alcohol screens. Please send this authorization form to the clinic with the employee.

Patient Name: _____ Appointment date and time: _____

Employer: _____ Agency (If a temporary employee): _____

Employer Contact Phone: _____

Authorized by: _____
Print Officer or Designated Employer Representative *Signature*

By signing this authorization, the above referenced employer acknowledges and agrees that it is financially responsible for all incurred charges, whether work related or non-work related.

| | |
|--|---|
| <input type="checkbox"/> Injury and/or Illness <i>Please Specify injury/illness to be treated:</i> | _____ |
| Physical Exams | <input type="checkbox"/> Pre-placement <input type="checkbox"/> DOT - Driver Medical Exam <input type="checkbox"/> Annual <input type="checkbox"/> Respiratory Clearance (includes physical exam and pulmonary function test) <input type="checkbox"/> PIV <input type="checkbox"/> Return to Work Exam <input type="checkbox"/> Fit for Duty Exam <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Employee to pay | |
| Non - Federal Drug Screen <i>Panel (Please Specify):</i> | <input type="checkbox"/> 5 Panel <input type="checkbox"/> 10 Panel <input type="checkbox"/> Collection only (employer's form) |
| <i>Type (Please Specify):</i> | <input type="checkbox"/> Instant (Instant report on negative screen) <input type="checkbox"/> Non-Instant (Send to lab for testing) |
| <i>Reason (Please Specify):</i> | <input type="checkbox"/> Pre-Placement <input type="checkbox"/> Post accident <input type="checkbox"/> Reasonable suspicion <input type="checkbox"/> Random <input type="checkbox"/> Follow-up |
| <input type="checkbox"/> Employee to pay | |
| Federal Drug Screen <i>Department (Please Specify):</i> | <input type="checkbox"/> DOT <input type="checkbox"/> Other: _____ |
| <i>Agency (Please Specify):</i> | <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG |
| <i>Reason (Please Specify):</i> | <input type="checkbox"/> Pre-Placement <input type="checkbox"/> Post accident <input type="checkbox"/> Reasonable suspicion <input type="checkbox"/> Random <input type="checkbox"/> Follow-up |
| Breath Alcohol Testing <i>Type (Please Specify):</i> | <input type="checkbox"/> DOT <input type="checkbox"/> Non-DOT |
| <i>Reason (Please Specify):</i> | <input type="checkbox"/> Pre-Placement <input type="checkbox"/> Post accident <input type="checkbox"/> Reasonable suspicion <input type="checkbox"/> Random <input type="checkbox"/> Follow-up |
| Immunization <input type="checkbox"/> Employee to pay | <input type="checkbox"/> Hepatitis B <input type="checkbox"/> TB <input type="checkbox"/> Flu Shot |
| Other Service | <input type="checkbox"/> Audiometer <input type="checkbox"/> Hepatitis B Titer <input type="checkbox"/> Fit Test Only <input type="checkbox"/> Vision <input type="checkbox"/> Other: _____ |