

**Employer's Authorization for Examination or Treatment**  
(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **SSN** \_\_\_\_\_ **Job Title** \_\_\_\_\_

**Patient Phone Number** \_\_\_\_\_ **Full-Time/Part-Time** \_\_\_\_\_ **Date of Injury/Incident** \_\_\_\_\_

**City of Macedonia** \_\_\_\_\_ **9691 Valley View Road, Macedonia, Ohio 44056** \_\_\_\_\_  
**Full Name of Company** \_\_\_\_\_ **Address** \_\_\_\_\_ **Company Box Code (For Drug Results Access)** \_\_\_\_\_

Physical Examinations	Substance Abuse Testing	Other Services
<input type="checkbox"/> Post Offer/Basic <input type="checkbox"/> OP&F Pension Fund <input type="checkbox"/> Annual <input type="checkbox"/> NFPA <input type="checkbox"/> HAZWOPR <input type="checkbox"/> Other: <input type="checkbox"/> HAZMAT <input type="checkbox"/> Chagrin/S.E. <input type="checkbox"/> Other: <input type="checkbox"/> DOT <input type="checkbox"/> Pre-Employ <input type="checkbox"/> ReCertification <input type="checkbox"/> Bus (T8) <input type="checkbox"/> Respiratory <input type="checkbox"/> Asbestos <input type="checkbox"/> Return To Work <input type="checkbox"/> Fit For Duty/Assessment <input type="checkbox"/> Other:	<input type="checkbox"/> Pre-Employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Work Related Injury/Illness/ Post Accident - <b>TREATMENT SOUGHT</b> <input type="checkbox"/> Follow-Up/Return To Work Other: <input type="checkbox"/> Urine Drug Screens <input type="checkbox"/> <input type="checkbox"/> Dot <input type="checkbox"/> 5 Panel <input type="checkbox"/> 10 Panel <b>NO TREATMENT</b> <input type="checkbox"/> 12 Panel <input type="checkbox"/> 5 Panel Rapid <input type="checkbox"/> 11 Panel Rapid <input type="checkbox"/> Other <input type="checkbox"/> W/Nicotine <input type="checkbox"/> Urine Collection Only <i>Send to:</i> <input type="checkbox"/> Breath Alcohol Test <input type="checkbox"/> Regulated <input type="checkbox"/> Non-Regulated <input type="checkbox"/> Hair Collection	<input type="checkbox"/> BWC Injury/Followup Care <input type="checkbox"/> Respirator Clearance <input type="checkbox"/> Respirator Fit Test <input type="checkbox"/> Qualitative <input type="checkbox"/> Quantitative <input type="checkbox"/> Hepatitis A Vaccine <input type="checkbox"/> Hepatitis B Vaccine (Series of 3) <input type="checkbox"/> Hepatitis B Antibody <input type="checkbox"/> TB Test <input type="checkbox"/> Skin <input type="checkbox"/> T-Spot <input type="checkbox"/> Tdap <input type="checkbox"/> MMR <input type="checkbox"/> PFT <input type="checkbox"/> Audiogram <input type="checkbox"/> Other:

**Billing**

BAT/UDS services as part of injury, illness or follow-up care:  
Bill the **CORPORATE HEALTH PLAN**

Injury Care: Bill the **WORKER'S COMPENSATION CARRIER**

Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Pre-Employment/Annual Occupational Health Services, Random and Reasonable Suspicion UDS: Bill the **CITY OF MACEDONIA**

Employee to **SELF-PAY** at the time of service

**IS TRANSITIONAL WORK/LIGHT DUTY OFFERED TO THE INJURED WORKER?**  Yes  No **ONLY IF TREATMENT IS SOUGHT**

**Authorized By** \_\_\_\_\_ **Title** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Date** \_\_\_\_\_