Employer Authorization Form

Employee/Applicant must bring PHYSICAL PHOTO ID to appt.

Employer Company Name:_____ Employer Telephone: _____

Employer Address/City/State/Zip:_____ Employer Fax: _____

Employer Contact: _____

Employer Contact Telephone: _____ Email: _____

Employee Name: _____ **Birthdate**:_____/_____/_____ Interpreter Needed? ☐ Language:_____

Employee Address/City/State/Zip:_____ Telephone: _____

EMPLOYEE HEALTH SERVICES **PLEASE MARK ALL APPROPRIATE SERVICES**

The above named employer authorizes UI Occupational Health to provide the following services to the above named employee/applicant:

DRUG AND ALCOHOL TESTING:

☐ Breath Alcohol Test	DOT	**CHECK:**		☐ Random	☐ Post-Accident	☐ Reasonable Suspicion	☐ Follow-Up	☐ Return to Duty
☐ Breath Alcohol Test	Non-DOT	**CHECK:**		☐ Random	☐ Post-Accident	☐ Reasonable Suspicion	☐ Follow-Up	☐ Return to Duty
☐ Urine Drug Screen	DOT	**CHECK:**	☐ Pre-Employment	☐ Random	☐ Post-Accident	☐ Reasonable Suspicion	☐ Follow-Up	☐ Return to Duty
☐ Urine Drug Screen	Non-DOT	**CHECK:**	☐ Pre-Employment	☐ Random	☐ Post-Accident	☐ Reasonable Suspicion	☐ Follow-Up	☐ Return to Duty

PHYSICAL EXAMINATION (Attach job description with essential job functions)

- ☐ DOT Physical (Hemoglobin A1C Blood Sugar Test if indicated? YES ☐ / NO ☐)
- ☐ Non-DOT Pre-Placement Physical
- ☐ Fit for Duty
- ☐ Surveillance/Periodic/Annual/Hazmat Exam

(Specify): _____

OTHER SERVICES (Mark all items that apply)

- ☐ Chest X-ray ☐ X-ray Other (Specify): _____
- ☐ EKG
- ☐ Hearing Test (Audiogram)
- ☐ Hepatitis B Vaccine Series ☐ F/U Hepatitis B Titer (Recommended)
- ☐ Other Vaccine (Specify): _____

OTHER SERVICES (Mark all items that apply)

- ☐ Laboratory Tests

(Specify): _____

- ☐ Pulmonary Function Test (Spirometry)
- ☐ Qualitative Respirator Fit Test (QLFT)
- ☐ Respirator Questionnaire Review
- ☐ TB test (Tuberculin Skin Test)
- ☐ TB test (QuantiFERON Gold Blood Draw)
- ☐ Urinalysis (dip stick method)
- ☐ Vision Screening (distance, near, horizontal fields, color vision)
- ☐ Lift Evaluation: Job Position: _____
- ☐ Other (Specify): _____

WORK-RELATED INJURY/ILLNESS

The above named employer authorizes UI Occupational Health to evaluate and treat the above named employee for an injury/illness reported to have occurred on the job or be job-related. We, the employer will pay all associated costs and will file the claim with our workers' compensation insurance carrier if appropriate:

☐ Work-related injury or illness (copy of accident report can be attached) Date of Injury: _____/_____/_____ ☐ Date unknown?

Body Part(s): _____ Nature of Injury/Illness: _____

Direct billing to: ☐ Employer: _____ ☐ Insurance Carrier: _____

INSURANCE INFORMATION:

Work Comp Insurer Name: _____ Phone: _____

Insurer Address: _____ City: _____ State: _____ Zip Code: _____

Claim #: _____ Fax: _____

WC ADJ Name: _____ ADJ Email: _____

***IMPORTANT* PLEASE MAKE SURE YOUR PREFERRED EMAIL AND/OR FAX IS CLEARLY LISTED FOR THE PREFERRED EMPLOYER CONTACT. THIS FORM IS NOT VALID UNLESS SIGNED BELOW.**

_____ ____ ____ ____

Signature and Title of Authorized Employer Representative (*REQUIRED*) **Date**

This form must be Emailed or Faxed, and received by UI Occupational Health at time of scheduling or prior to appointment.

2591 Holiday Rd - Coralville
occhealth@uiowa.edu
Phone: 319-356-3335
Fax: 319-467-7181
Hours Mon - Fri 8:00 am - noon and 1:00 pm - 5:00 pm

269 N 1st Ave (*lower level)- Iowa City
occhealth@uiowa.edu
Phone: 319-339-3921
Fax: 319-339-3858
Hours: Mon - Fri 7:00 am - 5:00 pm

After hours or in case of an emergency, send the patient (with this form) to any University of Iowa Urgent Care or Emergency Department. (Urgent Care Hours: Mon - Fri 7:00 am - 9:00 pm and Sat - Sun 7:00 am - 7:00 pm)