



AUTHORIZATION REPORT – Occupational Health Service
If injury has not occurred in the past 24 hours,
call for an appointment (517) 364-3900

AUTHORIZING COMPANY

Company: _____ Temp Agency (if applies): _____
Street: _____ City: _____ Zip: _____
Services authorized by: _____ Phone: _____ Date: _____
(Signature required)

EMPLOYMENT INFORMATION

Employee/Applicant Name: _____ Social Security Number: ____/____/____
Date of injury: _____ Approx. time of injury: _____ Time employee left site: _____
Nature of injury: _____
First aid treatment: _____
Position applying for: _____

SERVICES AUTHORIZED

Section I – Injury Care:

- Injury Care
- Post-Accident Drug/Alcohol Tests:
 - Drug Screen – DOT or Non-DOT (circle one)
 - Breath Alcohol – DOT or Non-DOT (circle one)

Section II – Other Drug/Alcohol Tests:

Patient instructions: DO NOT URINATE just prior to arriving; you must have a VALID PICTURE ID for photocopying.
Purpose of testing: Pre-placement Random Reasonable cause Return to duty/reasonable cause
Drug type: DOT Non-DOT Instant test
BAT type: DOT Non-DOT

Section III – Employment Physicals and Examinations: (scheduled appointments preferred)

Examination for:
 Pre-placement Physical Annual Physical
 DOT Physical: Initial Recertification
 Surveillance Exam (type): _____ Initial Periodic
 Second Opinion
 Fitness for Duty (for non-work related injuries/illnesses)
 Material Handling
 T.B. Testing Chest X-Ray for positive TB test
 Other _____