

Ascension Michigan at Work

Employer Authorization

For Treatment/Billing

Date: _____ Employee Name: _____
Job Title/Duties: _____
Employer: _____ Phone: _____
Address: _____
Street City State Zip

MINORS MUST BE ACCOMPANIED BY PARENT OR LEGAL GUARDIAN

Injury Care: (Describe) _____
Date of Injury: _____ Time: _____ ☐ a.m. ☐ p.m.
Controlled Substance Test with this injury: ☐ Urine Drug Screen ☐ Breath Alcohol Test

Patients treated after hours in Urgent Care or Emergency Department should return
for follow-up care at the nearest occupational health office.

Physical Exam (bring eyeglasses and/or contact lenses and case)

<input type="checkbox"/> Post-offer/Pre-hire	<input type="checkbox"/> DOT-new hire	<input type="checkbox"/> MCOLES
<input type="checkbox"/> Annual	<input type="checkbox"/> DOT-renewal	<input type="checkbox"/> Preventative Well Exam
<input type="checkbox"/> Return to Work	<input type="checkbox"/> Hazmat	<input type="checkbox"/> Silica Exam
<input type="checkbox"/> Other _____		

Drug and Alcohol Testing (photo identification required)

<input type="checkbox"/> DOT Urine Drug Screen	<input type="checkbox"/> Urine Drug Screen	<input type="checkbox"/> Breath Alcohol
<input type="checkbox"/> DOT Collection Only	<input type="checkbox"/> Collection Only	
<input type="checkbox"/> DOT Breath Alcohol	<input type="checkbox"/> Hair Testing	

Reason:

☐ Pre-Hire ☐ Random ☐ Post Accident ☐ Reasonable Suspicion ☐ Return to Duty ☐ Follow-Up ☐ Other

Screening/Immunization

<input type="checkbox"/> Audiogram	<input type="checkbox"/> TB Test (PPD)	<input type="checkbox"/> Lift Test
<input type="checkbox"/> Audiogram w/Analysis	<input type="checkbox"/> Hepatitis B Vaccination	<input type="checkbox"/> Pulmonary Function Test (PFT)
<input type="checkbox"/> EKG	<input type="checkbox"/> Hepatitis B Titer	<input type="checkbox"/> Vision Screen
<input type="checkbox"/> Respirator Questionnaire	<input type="checkbox"/> Travel Medicine (Rochester)	<input type="checkbox"/> Hepatitis A Vaccination
<input type="checkbox"/> Respirator Fit Test (No facial hair, No tobacco, food or drink (except water) one hour prior to test)		
<input type="checkbox"/> Other _____		

AUTHORIZED BY: _____
(please print) Phone

AUTHORIZED SIGNATURE: _____

ascension.org/michigan
Your Partner in Workplace Health & Wellness

