Northwestern Occupational Health

Keeping Workers Healthy In Our Community.

(***Patient Must Present Photo ID at Time of Service***)

Authorization for Examination or Treatment

Patient Name: _____ Date of Birth: _____

Employer: Franklin Central SU/ _____ **(school)**

Contact Information: Germaine Cross, 524-2600 Ext.17, gcross@fcsuvt.org,

IF the employer is not the school STOP HERE. Do not complete and send this form with the injured worker. They should contact their employer. (i.e.: ncss, the abbey)

Work Related

☐ **Injury** ☐ **Illness**

Date of Injury _____

Substance Abuse Testing* (Check all that apply)

☐ Regulated drug screen ☐ Breath Alcohol

☐ Non-Regulated drug ☐ Hair Collection

☐ Collection only

☐ Other_____

Type of Substance Abuse Testing*

☐ Pre-placement ☐ Random

☐ Post-Accident ☐ Follow-up

☐ Reasonable cause

Special Instructions/comments: _____

_____

_____ .

Authorized by:

_____

Phone:_____

Physical Examination

☐ Pre-placement ☐ Annual ☐ Baseline

☐ Exit

DOT Physical Examination

☐ Pre-placement ☐ Recertification

Special Examination

☐ Audiogram ☐ Respirator clearance ☐ PFT

☐ Other_____

Billing (Check if applicable)

☐ Employee to pay charges

☐ Bill to Company

☐ Bill to Workers Comp. Insurance

Due to the nature of these specific services, only the patient and staff are allowed in the testing /treatment area. Please alert your employee so that they can make arrangements for children or others that might otherwise be accompanying them to the medical center.

Title:_____

Date:_____

Insurance: VSBIT Multi-line Program, 52 Pike Drive, Berlin, VT 05602 802.223.5040