

Check One:



AUTHORIZATION FOR MEDICAL SERVICES

COMPANY NAME	EMPLOYEE'S NAME
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IF TEMPORARY EMPLOYEE – NAME OF TEMPORARY AGENCY _____

AUTHORIZED BY (SIGNATURE)	DATE SIGNED	PRINTED NAME
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TITLE	PHONE NO.
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_____ **Work-Related Injury** Date of Injury: _____

PHYSICAL EXAMS Check examination requested. Please request any other testing below.

_____ Post-offer Exam (Send job description if available)

_____ DOT Exam – New certification **CDL** ___ **Non-CDL** ___

_____ DOT Exam -- Re-certification **CDL** ___ **Non-CDL** ___

_____ FAA Physical _____ Travel Clinic

_____ School Bus Physical _____ Driving School Instructor Physical

_____ Respirator Examination

_____ Medical Surveillance Exam – Initial / Baseline: Type of exposure _____

_____ Medical Surveillance Exam – Annual / Interim: Type of exposure _____

_____ WorkSteps Exam

_____ Other: _____

OTHER TESTING

_____ Hearing Test (audiogram)	_____ Chest X-Ray ___ 1 View ___ 2 View
_____ Titmus Vision	_____ Urinalysis
_____ Respirator Fit Testing - Quantitative	_____ Pulmonary Function Test (Spirometry)
_____ OSHA Respirator Clearance Form	_____ Lab (Specify) _____

COVID TESTING

_____ Rapid COVID-19 Nasal Swab	_____ COVID-19 PCR Nasal Swab
_____ COVID-19 Antibody (Blood) Test	

IMMUNIZATIONS/VACCINATIONS

_____ Hepatitis B	_____ Hepatitis A	_____ Twinrix (HepA&B Combo)
_____ Tetanus/TDAP	_____ Typhoid	_____ Flu Vaccine
_____ TB Skin Test (PPD)	_____ Quantiferon (TB Gold)	
_____ Other (specify) _____		

SUBSTANCE ABUSE TESTING (Must have photo ID) Check type of test(s) and reason for test

TEST REQUIRED:	REASON FOR TEST:
_____ Urine Drug Screen w/MRO - DOT** (CDL Drivers)	_____ Pre-Placement/Post Offer
_____ Urine Drug Screen w/MRO - Non-DOT (Non-CDL Drivers)	_____ Reasonable Cause
_____ Urine Drug Screen – Collection Only	_____ Follow-Up
_____ Instant Drug Screen (pre-employment only)	_____ Random
_____ COMAR – Law Enforcement	_____ Post-Accident
_____ Breath Alcohol Test – DOT	_____ Return to Duty
_____ Breath Alcohol – Non-DOT	

****For Federal Drug Testing, please specify Testing Authority:**

_____ HHS _____ NRC _____ DOT - Please Specify DOT Agency:
 _____ FMCSA _____ FAA _____ FRA _____ FTA _____ PHMSA _____ USCG

Please complete Authorization for Services on reverse side.

Locations:



Frederick Health Employer Solutions
490-L Prospect Blvd
in the Weis Festival Plaza
Frederick, MD 21701
Appointments: 240-566-3001
FAX: 240-566-3003
Hours: Monday – Friday, 7 a.m. – 5 p.m.



Carroll Occupational Health
700-B Corporate Center Court, Suite A
Westminster, MD 21157
Appointments: 410-871-0470
Fax: 410-871-0743
Hours: Monday – Friday, 7 a.m. – 5 p.m.

We are no longer able to supervise unattended children in our clinics. We ask you to notify your employees to make appropriate child care arrangements before obtaining services at one of our locations.