UNIVERSITY OF IOWA HEALTH CARE
Occupational Health

Occupational Health
2591 Holiday Rd.
Coralville, IA 52241
319-356-3335 **Tel**
319-467-7181 **Fax**
OCCHealthNorthLiberty@uihealthsystem.org

Employer Authorization Form

Employer Name:_____ Telephone:_____

Employer Address:_____ Fax:_____

Employer Contact:_____

Telephone: _____ Email: _____

Employee/Applicant Name:_____

Employee's Address: _____ Employee's Phone: _____

Date of Birth:_____/_____/_____

EMPLOYEE HEALTH SERVICES

The above named employer authorizes UI Occupational Health to evaluate the above named employee/applicant for the following:

Please mark all appropriate services

DRUG AND ALCOHOL TESTING

Employee/Applicant must bring PICTURE ID to appointment

- ❑ Breath Alcohol Test DOT (circle: Random; Post-Accident; Reasonable Suspicion; Follow-up; Return to Duty)
- ❑ Breath Alcohol Test Non-DOT (circle: Random; Post-Accident; Reasonable Suspicion; Follow-up; Return to Duty)
- ❑ Urine Drug Screen DOT (circle: Pre-employment; Random; Post-Accident; Reasonable Suspicion; Follow-up; Return to Duty)
- ❑ Urine Drug Screen Non-DOT (circle: Pre-employment; Random; Post-Accident; Reasonable Suspicion; Follow-up; Return to Duty)

PHYSICAL EXAMINATION (Attach job description with essential job functions)

- ❑ DOT Physical
- ❑ MD Physical
- ❑ RN Physical
- ❑ Surveillance/Periodic/Annual/Hazmat Exam:

Specify _____

OTHER SERVICES (Mark all items that apply)

- ❑ Chest X-ray
- ❑ EKG
- ❑ Hearing Test (Audiogram)
- ❑ Hepatitis B Vaccine

OTHER SERVICES (Mark all items that apply)

- ❑ Laboratory Tests:

Specify_____

- ❑ Pulmonary Function Test (Spirometry)
- ❑ Respirator Fit Test
- ❑ Respirator Questionnaire Review
- ❑ TB test (IPPD method)
- ❑ Urinalysis (dip stick method)
- ❑ Vision Screening (distance, near, horizontal fields, color vision)
- ❑ X-ray Other:

Specify_____

- ❑ 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 _____/_____/_____ ❑ Unknown

Body Part: _____ Nature of Injury/Illness_____

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

INSURANCE INFORMATION

Claim#:_____ Phone: _____

WC Insurer Name: _____ Fax: _____

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

WC ADJ Name: _____ ADJ Email: _____

_____ _____/_____/_____

Signature and Title of Authorized Employer Representative **Date**

This form must be received by UI Occupational Health prior to medical treatment or physical.
After hours or in case of an emergency, send the patient (with this form) to the University of Iowa Hospital Emergency Trauma Center.