McLeod Occupational Health

OCCUPATIONAL HEALTH SERVICES
555 E. Cheves Street
Florence, S.C. 29506
Phone#: 843-777-5146 Fax#: 843-777-5159

EMPLOYERS AUTHORIZATION FOR EXAMINATION OR TREATMENT

PATIENT NAME:____________________________ SSN#:______________________

COMPANY NAME:___________________________ DATE OF BIRTH:____________

ADDRESS:_________________________________ DATE OF INJURY:__________

Appointment Date and Time:_______________________________________

PHYSICAL EXAMINATIONS

____ DOT New Certification
____ DOT Recertification
____ Routine Physical Exam
____ Complex Physical Exam
____ Chromium
____ Respirator Certification
____ Hazmat
____ Other______________________

IMMUNIZATIONS

____ MMR ____ PPD
____ Influenza ____ Tetanus
____ Hepatitis A ____ Hepatitis B

DRUG/ALCOHOL TESTING

____ Federal Regulated (DOT)
____ Non-Regulated (Non-DOT)
____ Urine Collection Only
____ Automatic UDS
____ Hair Collection
____ Breath Alcohol (DOT)
____ Breath Alcohol (NON-DOT)

TEST TYPE

____ Preplacement
____ Random
____ Reasonable Suspicion
____ Post Accident
____ Periodic
____ Follow-up
____ Return to Duty

WORK RELATED INJURY

Post Accident Drug Screen Required
Yes_____ No_____

BILLING

____ Bill Company for Services
____ Bill Workers' Compensation Carrier

Carrier:____________________________
Address:____________________________
____
Phone#:____________________________
Policy#:____________________________

Authorized by:______________________________ **Title:**________________________

Phone:___________________________________ **Date:**_________________________