



AUTHORIZATION FOR TREATMENT

ALL services included in the account profile for respective service WILL be performed unless otherwise stated

Company Name _____ Location _____
Employee or Prospective Employee Name _____
Company representative authorizing service _____ Phone _____
Signature of authorization _____ Date _____

Occupational Health Locations

PH: 734-333-8001 FAX: 734-333-8002

Table with 6 columns: DEARBORN, GARDEN CITY, TAYLOR, LIVONIA, SOUTHFIELD, BLOOMFIELD. Each column lists phone numbers, addresses, and hours of operation.

COVID-PCR Test COVID-RAPID Test Antibody test Company pay Employee pay

WORK RELATED INJURY TREATMENT:

Date of injury _____

PHYSICAL EXAMINATIONS:

- Pre-Placement Exam
Return to Work Exam Fit for Duty Exam
DOT Recertification DOT Exam
Firefighter Physical MCOLES (Police physical)
Hazmat physical Asbestos physical

DRUG AND ALCOHOL SCREENING:

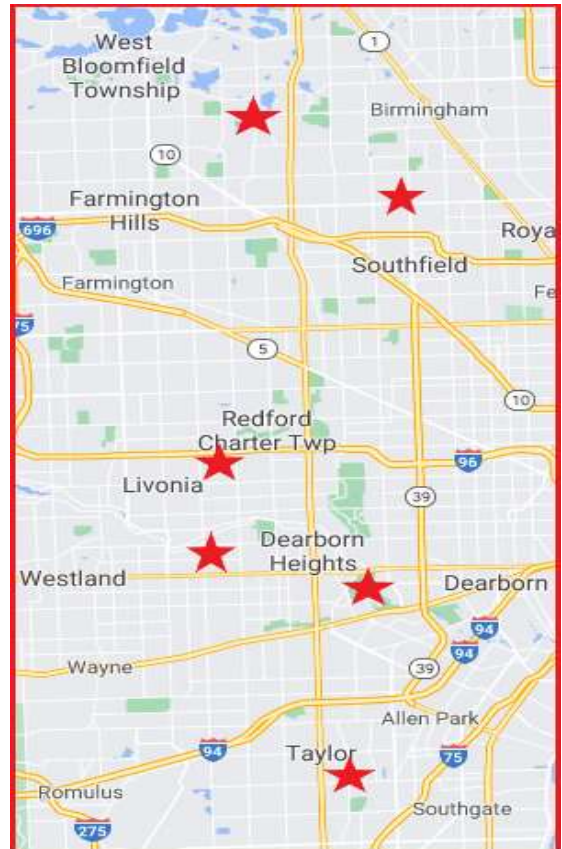
- 5 Panel 10 Panel
Instant Lab send out
Breath alcohol test
Non-Regulated (Non-DOT) Regulated (DOT)

Reason for screening:

- Pre-Placement Random Reasonable Suspicion
Post Accident/Injury Follow-Up

VACCINATIONS AND LABORATORY SERVICES:

- PPD/TB PPD/TB 2 Step TDAP Hepatitis B Series
Titers Urinalysis Other



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