



MBI OCCUPATIONAL HEALTHCARE TREATMENT AUTHORIZATION FORM

(MAP, ADDRESSES, PHONE NUMBERS AND HOURS ON BACK)

Today's Date: _____

Company Name: _____

Employee's Name: _____

Co. Representative: (print) _____ Phone: _____

Co. Representative: (signature) _____

Worker's Comp. Co: _____ Policy No. _____

<u>Reason for visit:</u>	<u>DRUG SCREENS</u>	<u>EXAMS</u>	<u>OTHER SERVICES</u>
<input type="checkbox"/> Pre-placement	<input type="checkbox"/> Instant Drug Screens	<input type="checkbox"/> Physical Exam	<input type="checkbox"/> Respiratory Clearance
<input type="checkbox"/> Recert/Annual	<input type="checkbox"/> 5-panel	<input type="checkbox"/> DOT Exam	<input type="checkbox"/> Mask Fit
<input type="checkbox"/> Post Accident	<input type="checkbox"/> 9-panel	<input type="checkbox"/> Bus Driver Physical	<input type="checkbox"/> PFT
<input type="checkbox"/> Injury Treatment	<input type="checkbox"/> Regulated	<input type="checkbox"/> Asbestos Exam	<input type="checkbox"/> TB Skin Test
<input type="checkbox"/> Reasonable Susp/Cause	<input type="checkbox"/> Non-Regulated	<input type="checkbox"/> Hazmat Exam	<input type="checkbox"/> X-Ray
<input type="checkbox"/> Random	<input type="checkbox"/> Breath Alcohol Test	<input type="checkbox"/> Baseline	<input type="checkbox"/> EKG
<input type="checkbox"/> Follow up	<input type="checkbox"/> Hair Test	<input type="checkbox"/> Annual	<input type="checkbox"/> Blood Draw
		<input type="checkbox"/> Exit	<input type="checkbox"/> Immunization type _____
		<input type="checkbox"/> Return to work	<input type="checkbox"/> Audiogram
			<input type="checkbox"/> Vision Testing

Other information: _____
