❑ Annawan ❑ Colona

Medical Authorization

Date: ___________

Employee Name: ______________________________ Employer Name: _________________________

Authorized By (name): ____________________________ Telephone # (____) _____________________

Request is Void After: ____________________ ________________________
(Date) (Time)

Date and Time of Injury: _________________________ Type of Injury: ____________________________

Person responsible for payment: Company _____________________ Employee _______________

Please select testing that your company requires
Only testing indicated will be done

Exams

DOT Exam: ❑ Exam ❑ Drug Screen ❑ Alcohol Screen

Work Physical: ❑ Exam ❑ Drug Screen ❑ Alcohol screen

School Bus Physical: ❑ Exam ❑ Drug Screen ❑ Alcohol screen

Other (specify): ____

Reason for Test

❑ Pre-employment ❑ Random ❑ Reasonable Suspicion ❑ Post Accident

Please check (✓) ❑ Return to Duty ❑ Follow up ❑ Other (specify): ________________________

Other

❑ TB Skin Test ❑ List Test ❑ Influenza Vaccination ❑ Tetanus

❑ Hepatitis A Vaccination ❑ Hepatitis B Vaccination ❑ Hepatitis B Surface Antibody

❑ Other (specify): ____

HHH Staff Only

Faxed to MRO: Date: _______________ Initials: _________

Results sent: Date: _______________ ❑ Fax ❑ Mail

_________________________________ __________________
Office Staff Date

F-125 C (5/18)