



### OCCUPATIONAL HEALTH REGISTRATION

#### To be Completed by the Employer

EMPLOYER INFORMATION:

Company Contact: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Company: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

This employee of our company requires the following services:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Injury Care                             | <input type="checkbox"/> 10-Panel Drug Screen             | <input type="checkbox"/> Pre-Employment Physical |
| <input type="checkbox"/> Injury Care with Drug or Alcohol Screen | <input type="checkbox"/> 10-Panel Drug and Alcohol Screen | <input type="checkbox"/> CDL/DOT Physical        |
| <input type="checkbox"/> Re-check / Re-evaluation                | <input type="checkbox"/> NIDA Drug Screen (DOT)           | <input type="checkbox"/> Respirator Physical     |
| <input type="checkbox"/> Breath Alcohol Screen                   | <input type="checkbox"/> 5-Panel Non-NIDA Drug Screen     | <input type="checkbox"/> Mantoux (TB Test)       |
| <input type="checkbox"/> Hearing Test                            | <input type="checkbox"/> 5-Panel Rapid Drug Screen        | <input type="checkbox"/> Hepatitis B Vaccine     |
|  |   | <input type="checkbox"/> Hepatitis B Titer       |

Special Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Authorized by: \_\_\_\_\_

**A Photo I.D. is Required for all Drug and Alcohol Testing**

#### To be Completed by the Employee

EMPLOYEE INFORMATION:

Last Name: \_\_\_\_\_ First & Middle Name: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Sex: \_\_\_\_ (M/F) Marital Status: \_\_\_\_ (S/M) Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

#### To be Completed by MedStat

#### **Consent to Treatment**

I hereby consent to and authorize my physician, other designated physician, and associated medical staff the administration and performance of all treatment, minor operations, and procedures, which, in the judgment of the physicians or designated alternate, may be considered necessary or advisable for my care. If I do not comply with the medical program of care provided or recommended by my physician or designated alternate, I understand that such action may result in adverse medical consequences and I then relieve my physician, designated alternate, and associated medical staff of all responsibility for consequences resulting from my action.

If my treatment is necessary due to an on the job injury (a workers' compensation claim), then I hereby authorize the physician to release any medical or financial information to all such entities that are responsible for adjudicating the claim, including, but not limited to, the Indiana Workers' Compensation Board, my employer, and any third party payor/administrator, medical claims review agent, or their legal representatives.

- |  |                              |                             |                         |
|--|------------------------------|-----------------------------|-------------------------|
| 1. Have you read this form or had this form read to you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                         |
| 2. Do you understand this form?                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                         |
| 3. Do you have any questions?                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Patient Initials: _____ |
| 4. Have you received a copy of our privacy notice?       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Patient Initials: _____ |

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_