Employer Authorization

Thank you for choosing CRH Occupational Health! Please print clearly to complete this form in its entirety so that we may process your employee's visit efficiently and accurately. This form should be completed by a Designated Employer Representative and may be hand carried by the employee or faxed.

Date:______________________________ Date of Service:______________________________

Patient Name:______________________________

DOB:______________________________ SSN:______________________________

Company / Plant Name:______________________________

Company Address:______________________________

Reason: ☐ Random ☐ Post Accident ☐ Reasonable Susp
☐ Annual ☐ Promotion ☐ Pre-Employment

☐ **DOT** ☐ **Non-DOT**

Services Authorized by:

First Name:______________________________ Last Name:______________________________

Phone:______________________________ Fax Number:______________________________

****Please note if you are not an existing account with PromptMed, a protocol will need to be established prior to performing services for your employees. Contact our office at (812) 376-5104.

☐ **Work Comp Initial** ☐ **Work Comp Follow-Up Visit**

Drug Screen ☐ DOT ☐ Non-DOT

☐ 5 Panel Instant ☐ 5 Panel Lab Base ☐ 9 Panel Lab Base

☐ 10 Panel Instant ☐ 10 Panel Lab Base ☐ DOT 5 Panel

☐ 5 Panel Hair Test ☐ Company uses 3rd party vendor for drug screens

☐ **BAT** ☐ DOT ☐ Non-DOT

☐ **Physical** ☐ DOT ☐ Non-DOT

☐ **PPD** ☐ 2 Step ☐ Chest X-Ray ☐ Quantiferon

☐ **Immunization**

☐ Spirometry ☐ Audio

☐ Other Services Ordered:______________________________

Notes:______________________________

____

____

Occupational Health Employee:______________________________

Fax this form to (812) 376-5108.

Phone: (812) 376-5104
237 Washington Street
Columbus, IN 47201

Hours: M-F 7am - 5 pm

OCCUPATIONAL HEALTH
COLUMBUS REGIONAL HEALTH

PMR-106 (08/15/19) b&w